

150 Years of British Psychiatry

VOLUME II The Aftermath

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150 Years of British Psychiatry

Volume II: The Aftermath

Edited by Hugh Freeman &
German E Berrios

Following *150 Years of British Psychiatry 1841-1991* (1991), the editors have compiled a second volume complete with index dealing with the principal developments in British psychiatry during the twentieth century and covering its most important conceptual and practical achievements. Accounts are provided of important episodes in British psychiatric history which have never been described adequately before. With Volume I, this second volume constitutes the definitive history of British psychiatry since its formation during the nineteenth century.

The Editors

Hugh Freeman is a Consultant Psychiatrist, former editor of the *British Journal of Psychiatry* and *Current Opinion in Psychiatry*, and has written many books in the field. German Berrios is Consultant and University Lecturer in Neuropsychiatry at Cambridge University and the author of many books in this area.

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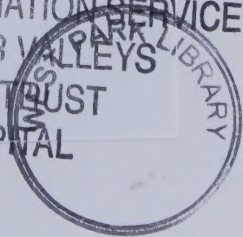
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150 Years of British Psychiatry

Volume II: the Aftermath

Edited by
Prof. Patricia A. Carnahan, B.M.S.

150 Years of British Psychiatry
Volume II: the Aftermath
London: Taylor & Francis, 2001

First published 1996 by The Athlone Press Ltd
1 Park Drive, London NW11 7SG and
165 First Avenue, Atlantic Highlands, NJ 07716

© H.L. Freeman and G.E. Berrios 1996

ISBN 0 485 11506 9

British Library Cataloguing in Publication Data

*A catalogue record for this book is available
from the British Library*

Library of Congress Cataloging-in-Publication Data
(applied for)

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Publication of this book was made possible with the help of an educational grant from Zeneca plc.

Typeset by Bibloset
Printed and bound by the University Press, Cambridge

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Introduction

HUGH FREEMAN and GERMAN E. BERRIOS

The introduction to our well received *150 years of British Psychiatry 1841-1991* carried a *caveat emptor*. 'Inevitably, a book of this nature must be incomplete, and the editors are painfully aware of some of its gaps. Most noticeable amongst these topics are the role of the European *émigrés* . . . the history of some treatments such as drugs and convulsive therapies, mental nursing and clinical psychology' (Berrios & Freeman, 1991, p.xiv). Readers will be pleased to know that many of these gaps have been made good in this second volume, which we hope will not be not the last one, on the history of British psychiatry.

For reasons which themselves merit attention, the history of British psychiatry has not been given the scrutiny it deserves. It is no exaggeration to say that the definitive work on the contribution of Britain to what within these shores has been quaintly called 'psychological medicine' still remains to be written. This is the more surprising because, since the nineteenth century, British clinicians and historians have shown that, when needed, they can produce first-rate (albeit focused) historical work. An early example is *Chapters in the History of the Insane in the British Isles* (Tuke, 1882) published at the time when, under the aegis of the Medico Psychological Association, psychiatric practice was becoming more uniform across the British Isles. Thus, Tuke was careful to include sections on Scottish and Irish psychiatry, and also a survey on 'The progress of psychological medicine during the last forty years: 1841-1881' which, surprisingly enough, contained much information on Continental Europe.

An example of historical analysis driven by need is the cluster of books that appeared around the Second World War, starting with the volume edited by Emanuel Miller (1940). This gives an excellent historical and clinical account of the *Neuroses in War* and brought together such important figures as Bion, Critchton Miller, Culpin, Dillon, Hadfield, Hargreaves, Spillane, Wilson, and Wittkower (author of the superb historical chapter). It was followed by the work of James Mackintosh (1944) from Glasgow, examining the impact of the conflagration on the 'mental health of the nation'. Soon after, J.R. Rees (1945), then medical director of the Tavistock Clinic and previously Director of Army Psychiatry, discussed in *The Shaping of Psychiatry by War* how various clinical concepts and practices had been changed by the conflict. Lastly, there is the useful *Psychiatry in the British Army in the Second World War* by Robert H. Ahrenfeldt (1958), which J.R. Rees called 'an important fragment of history'.

The 1950s witnessed the start of the scholarly work by that redoubtable mother-and-son pair that were Ida Macalpine and Richard Hunter. Writing from the intellectual comfort of their extraordinary library – started by Ida's father, a Nuremberg clinician-historian – they contributed to all genres of psychiatric history. For example, *300 Years of Psychiatry 1535-1860*, (Hunter & Macalpine, 1963a) is valuable for its sheer compendiousness: including (annotated) morsels from more than 350 books of central relevance to the history of psychiatry (more than half, in fact, being rare documents), it remains an obligatory starting point for the beginner searching for leads into the great labyrinth of pre-twentieth century views on madness. But there is much more by them: *Schreber's memoirs* (Macalpine & Hunter, 1955), *Schizophrenia 1677* (Macalpine & Hunter, 1956), *A Treatise on Madness* by William Battie (edited by Hunter & Macalpine, 1962a), *Richard Lower: De Catarrhis 1672* (edited by Hunter & Macalpine, 1963b), the three Conolly books (Hunter & Macalpine, 1964a, 1968, 1973), and Tuke's *Description of the Retreat* (edited by Hunter & Macalpine, 1964b) remain excellent instances of how to undertake an edited facsimile reproduction. And there were also full-length historical works: *George III and the Mad-Business* (Macalpine & Hunter, 1969) put forward a clinical hypothesis to explain the behaviour of the unfortunate king, and *Psychiatry for the Poor* (Hunter & Macalpine, 1974) is a model of institutional history.

Monographs on mental institutions or people have been popular, and some are well known. For example, Ralph Partridges's (1953) *Broadmore*, Ashworth's (1975) *Stanley Royd Hospital*, Foss & Trick's (1989) *St. Andrew's Hospital*, Cooper & Bird's (1989) *The Burden Institute*, Crammer's (1990) *Asylum History: Buckinghamshire County Pauper Lunatic Asylum*, and Whitmore's (1983) *Mad Lucas*.

Works by British writers covering wider periods or topics have also appeared over the years. For example, Basil Clarke's 'exploratory studies' on *Mental Disorder in Earlier Britain* (1975) remains unsurpassed for its richness of data and quality of expression. William Parry-Jones's *The Trade in Lunacy* (1972) set new scholarly standards, particularly if it is remembered that its author was at the time a young lecturer in psychiatry at Oxford. In the same mould, later monographs such as *Madness, Morality & Medicine* (Digby, 1985), a major study of the York retreat, can be considered. There is also the work of Kathleen Jones (1972) whose *History of the Mental Health Services* for the first time gave British psychiatrists a longitudinal account of the manner in which their concepts and practices had been shaped by changes in legislation. This was brought up to date by her *Asylums and After* (1994).

Most of the books mentioned above focused on the nineteenth century and after. Denis Leigh's (1961) biographical coverage of some eighteenth-century figures remained for years the exception, until three important works appeared which threw the seventeenth and eighteenth centuries wide open. Based on a detailed analysis of Richard Napier's clinical log-book, Michael MacDonald (1981) undertook in his *Mystical Bedlam* a superb study of the language and ideology of mental disorder in seventeenth-century England. This was followed by Roy Porter's (1987) *Mind-Forg'd Manacles*, where a survey ranging from Charles II to the early nineteenth century was made of the cultural and social basis of psychological medicine. More recently, G.S. Gross (1992) has published a fine study of late eighteenth-century psychopathological ideas revolving around the views of Samuel Johnson.

Social historians have also written on aspects of British psychiatry, particularly the 'psychiatric profession'. Examples of these are Andrew Scull's *Museums of Madness* (1979) – (updated in 1993), and his edited book on Victorian psychiatry (1981). In a similar vein were the books by Donnelly (1983) on early nineteenth-century Britain, and Busfield (1986), which emphasised the role of sociological variables in the origin of British psychiatry. In introducing our previous volume, we pointed out some of the illogicalities of 'revisionist' attacks on psychiatry's record, particularly their lack of understanding and of realism as to what was therapeutically possible at any particular period. Since then, Crammer (1994) has shown that the 'psychiatric profession', on which revisionists have so often vented their spleen, did not exist as an identifiable body until well into the present century. He has also pointed out that an institution containing several hundred people, many of them admitted suffering from infection, malnutrition, or concomitant bodily disorders, had great need of the services of medical general practitioners – as then understood. For that reason, early asylum doctors were often described as 'surgeons' (having an MRCS qualification, not an MD, and described as 'Mr'.) or as 'apothecaries' (licensed to practice by the London Society of Apothecaries). Although the first organization of specialists in mental disorder was founded in 1841, it was puny in size and quite without influence for many decades. British psychiatrists did not have a qualification comparable with that of the older-established specialties until 1971. What the 'revisionists' have been attacking was in fact largely an Aunt-Sally of their own creation, particularly as a defined medical profession in England only dates from 1858.

This point has been well made by Donnelly (1991): 'It is hard to identify those 'segments of the medical profession' which . . . successfully manoeuvred to institutionalise psychiatry . . . It is easy to see psychiatrists as beneficiaries of the roles which they . . . occupied in asylums. It requires another set of arguments, however, to show that earlier on, it was a self-conscious professional strategy which secured these roles . . . it is difficult to find evidence early in the nineteenth century of a proto-profession . . . already acting to defend corporate interests . . . [this professional group] is not seen to be transformed or to evolve in the process of adapting to the conditions of an asylum-based practice' in the 'revisionist' account.

It is also necessary to examine critically the view of some sociologists that psychiatric symptoms are merely 'labelled' violations of social norms which only arise in a particular society. Important evidence on this point was obtained by Turner (1992), who rigorously applied modern diagnostic criteria to the case-books for the years 1845-1890 of the Ticehurst House Asylum. He found that the two major diagnostic categories of schizophrenia and manic-depressive psychosis had in fact remained stable over the course of the century. Not only was any culture-bound definition of mental illness negated by this analysis, but the records provided much evidence of the humanitarian qualities of nineteenth-century doctors and nurses, despite the violent nature of many patients that they cared for. The danger of the sociological view of mental illness, as Turner points out, is that modern community care may be based on naïve and false assumptions, e.g. that psychiatric patients are not 'really' ill.

However, there have also been other British historians of psychiatry who have preferred the scholarly paper to communicate their ideas. In this regard, we may

still wonder what was missed by Alexander Walk (for many years the Honorary Librarian of the *Royal Medico-Psychological Association*) never writing a full-length book on the history of British psychiatry, or by Edward Hare so far depriving us of a similar pleasure.

But for all these scholarly contributions, vast landscapes in the past of British psychiatry remain unexplored. As a consequence, a sort of received view seems to have formed along the following lines: (a) clinical concepts, classifications, and practices were developed in France during the first half of the nineteenth century, and in Germany during the second half; (b) during this same period, and due to specific social factors and legislation, English (and eventually British) psychiatry followed a *sui generis* path; up to the Great War, its only contribution was in the area of institutional administration; (c) British psychiatry remained impervious to the ideological attack of psychoanalysis (which markedly influenced other nations such as the USA); and (d) since the Second World War, it has been a world leader on account of an eclectic institutional approach, a strong psychopathological tradition, and hard-nosed empiricism.

How true this picture is remains to be seen. For example, is it really the case that nineteenth century British alienists were conceptually unproductive and simply followed their continental colleagues? The literature shows that clinical concepts such as moral insanity, hallucination, delusions, stupor, dementia, moral responsibility in mental illness, obsession, etc. were in fact treated differently in Britain, and that these views influenced continental writers. Maudsley was translated into German, French, Italian, and Spanish, and the work on clinical concepts by Sully, Jackson, Clouston, Ireland, Newington, Tuke, Crichton-Brown, Savage, etc. was well known and often quoted on the European Continent.

Was British psychiatry between 1900 and 1939 impervious to psychoanalysis? Although the definitive work on this has not yet been published, it is likely that such a claim needs qualifying. Practice in the lunatic asylums, mainly dealing with organic disorders and chronic psychoses, may not have been influenced by Freudian ideas (see chapters by Clark, Miller, Parfitt, and Tantam, this volume). However, it was otherwise in the case of psychiatrists researching on shell shock during the First World War (see Merskey, this volume), who soon realised that more 'psychological' models were needed. Likewise writers like Hart, Brown, McCurdy, Ross, Nicole, (and many others) remind one of the fact that even before 1933, psychoanalytical ideas were taken very seriously in Britain (Berrios, 1991).

In that case, when (and why) did British psychiatry become empirical and eclectic in approach, and solidly clinical in psychopathological description? An interesting observation in this regard is that British publications in psychiatry circa 1930 give no inkling that such was going to be the future of psychiatry in this country. Therefore, an important event is likely to have taken place in the following decade that brought to Britain a new descriptive psychopathology, a firmer clinical and neurobiological approach to mental disorder, and a statistical, quantitative scientific canon (see chapters by Bird, Crammer, Turner and McGuffin & Gottesman, this volume). Such changes, as Professor U. Peters shows in his chapter, were due to the arrival of refugees such as Mayer-Gross, Guttman, Strauss, Stengel, and Mayer.

In the present volume, chapters have been grouped into three sections: clinical

practice, profession, areas and institutions, and people. They mainly cover the development of British psychiatry during the twentieth century, but many extend further back in their coverage. Chapters will be found on the history of ECT and psychopharmacology, on drug addiction, eating disorders, mental deficiency, and the little known 'low moral fibre' syndrome, used during World War II to describe air crew who had developed phobias of flying. The second section offers new material on the history of psychiatry in Northern Ireland, Scotland, and Wales, and on institutions such as the Maghull Military Hospital and Institute of Psychiatry. Lastly, Hitch, Golla, Graves, Slater, Fairbairn, Winnicott, and Maxwell Jones feature prominently in the section on people. We feel that these chapters speak for themselves and that it is unnecessary to either summarise or extol them. It had been intended that a chapter on the history of community psychiatry by one of us (H.L.F.) would be included, but this has grown to such an extent as to require separate publication.

Once again, it has not been the intention of the editors to offer in this volume a complete history of twentieth-century British psychiatry. The selection of topics has been governed less by a pre-conceived idea of what is important during this period than by what British historians were able to offer at this stage. Equally important to such choice has been the contents of our earlier volume, and the editors recommend that the two are read in conjunction. We shall do our best to fill the remaining gaps in a future third volume.

H.L.F. and G.E.B.

January 1996

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I. Clinical Practice

1 Early Electroconvulsive Therapy in Britain, France and Germany: a conceptual history

G.E. BERRIOS

Writing on the history of biological treatments, particularly identifying origins and end-points, is a complex matter. For example, when working on an earlier piece on the history of psychosurgery, it soon became apparent that starting with Moniz (as conventional accounts tend to do) was not satisfactory (Berrios, 1991). Apart from the historical fact that this is not correct, there was also the question of the nature and origin of the *social and moral warrants* that led Moniz to propose such a major surgical procedure, as well as the need to tell the story, viz.- the constitution of a *scientific warrant* that clearly started before his time.

The history of the convulsive therapies does pose a similar problem. First of all, there are the 'facts' (people, dates, and events) and the question of 'priorities' and influences; then a host of social and moral factors without which it would be impossible to understand their history; and lastly, the question of what definition of electroconvulsive therapy to use. The one provided by the Royal College of Psychiatrists (1989) is not very useful for historical purposes, as it almost eliminates the work of Cerletti and Bini, who did not use certain electrical parameters and modifications. But to use a definition that simply referred to the use of electricity in the treatment of mental disorder would be equally unhelpful. To deal with this difficulty, the historian must make use of other definitional criteria such as the intentional induction of controlled convulsions and the availability of supporting scientific hypotheses and adequate moral warrants.

Definitions and their history

The term 'convulsive therapies' refers to a group of medical procedures whose objective is the treatment of certain mental disorders by means of an induced fit. Seizure-inductors have ranged from (injected or inhaled) substances (such as metrazol or fluorothyl) to the passing of an electrical current through the brain. This chapter specifically deals with the history of the latter, of what is now called electroconvulsive therapy (ECT).

The early convulsive therapies (e.g. cardiazol) were based on the hypothesis that there was a negative correlation between schizophrenia and epilepsy

(Meduna, 1938). This view was based on both epidemiological (Krapf, 1928) and neuropathological (Nyirö & Jablonsky, 1929) work: the former suggesting that having one disease protected from the other, the latter that nerve fibres were thinner in schizophrenia than in epilepsy. Inducing artificial seizures in subjects with schizophrenia might thus cause nerve hypertrophy and alleviate their mental disorder (Meduna, 1934). These ideas were encouraged by the development during the 1930s of other biological treatments such as insulin coma (James, 1992) and psychosurgery (Berrios, 1991), and by the reaction against psychodynamic ideas and the over-complex model of Adolph Meyer (Gelder, 1991).

Three periods can be identified in the evolution of ECT. The first, extending from the beginnings to 1945, covers early work on the neurophysiology of ECT, the mental disorders which most benefited from it, and the realisation that the scientific basis on which cardiazol therapy had been founded was no longer valid. The second period reaches the late 1950s, the time of the important debate on unilateral and bilateral placing of electrodes and the completion of the research into modifications to alleviate side-effects. The third period, stretching from then to the present, includes a review of clinical indications and side effects, updating of neurobiology and endocrinology, and a return to concerns with 'seizure duration'. In keeping with the historical span covered by this book, this chapter will only deal with the first period.

The beginnings

Within a few months of the beginning of the Second World War, Fleming, Golla, & Walter (1939) published in *The Lancet* what can be considered as the first trial of ECT in England. Writing from the Burden Neurological Institute in Bristol (see Bird, this volume), they set out to test 'the method devised by Cerletti and Bini (1938) of inducing major convulsions by electrical stimulation of the brain' in five schizophrenic patients. Fleming *et al* 'administered 75 shocks, as a result of which there have been 50 major convulsions and 25 minor seizures. The major convulsions are similar to spontaneous ones and are followed by complete amnesia for the shock'. The authors concluded that 'no untoward results have been observed; the claims of Cerletti and Bini are confirmed; the method is technically effective, simple and safe and arouses no fear or hostility in the patients'. The authors made 'no attempt to assess the therapeutic value of the method, which Cerletti and Bini state is the same as that of cardiazol' (p.1355), but speculated on a link between seizure induction, area 6aß of Vogt, and epilepsy (for a discussion of this issue see below).

The *Lancet* paper is important, as its views on the acceptability and feasibility (an early Phase II study) of ECT reassured the British psychiatric world that a safe method of inducing seizures had been found.¹ That the authors did not assess therapeutic effects, but quoted Cerletti and Bini's view that they were 'equivalent to those of cardiazol' is a crucial point, as it shows that ECT was introduced as a variant of cardiazol, rather than as a new treatment. Because of this, we need to explore, albeit briefly, the history of the convulsive therapies.

TABLE 1

<i>Differences between epilepsy and schizophrenia (Modified from Meduna, 1938)</i>		
	<i>schizophrenia</i>	<i>epilepsy</i>
Physique	ectodermal	mesodermal
Glial system	reduced	increased
carbohydrate metabolism	decreased	increased
clinical antagonism (a)	few cases with epilepsy	few cases with schizophrenia
response to treatment	improves if patient develops epilepsy	improves if patient develops schizophrenia

(a) Meduna obtained support for the biological antagonism hypothesis from Nyirö & Jablonsky's (1929) classical paper on epilepsy.

The convulsive therapies

As mentioned above, the convulsive therapies were based on the view that there was a neurobiological opposition between epilepsy and schizophrenia. This excludes insulin coma therapy (based on a different scientific rationale)² and also earlier episodes in which 'electricity' was used as a form of treatment.³ In their narrow sense, the convulsive therapies were developed by Ladislav Joseph von Meduna.⁴ At the 89th Meeting of the Swiss Psychiatric Association, Meduna argued that whilst there was no evidence for the view that insulin 'reversed the predominance of old over new fibres in the brain of schizophrenics', there was plenty of evidence in favour of a biological antagonism between epilepsy and schizophrenia (see Table 1).

Meduna (1938) concluded that: 'Between schizophrenia and epilepsy there exists a sort of biological antagonism which must be expressed in the pathological course of the two diseases . . . I feel justified in asserting *a priori* that these courses are either mutually exclusive or they do, at least to a great degree, weaken each other in their mutual effects' (pp.44-5).

The antagonism between epilepsy and schizophrenia

By the early 20th century, all three possible options exploring the relationship between epilepsy and schizophrenia (dementia praecox) had been discussed in some detail. These included both a positive and a negative correlation (i.e. antagonism) as well as no association at all (Berrios, 1995b). Which view predominated was determined by research, fashion, and periodic changes in the definitional boundaries of the conditions involved (Flor Henry, 1976).

For example, up to the 1910s, the view had been popular that epilepsy and dementia praecox were correlated,⁵ but in the period between the Wars, the opposite view was to gain the upper hand. The 'biological antagonism hypothesis' received crucial support from the work of Glaus (1931), who in 6,000 subjects with schizophrenia found a prevalence of epilepsy as low as 0.13 %; furthermore, he observed that in the eight patients in which both conditions were combined, there was an alternation of the conditions.

However, by the late 1930s, improved statistical work began to show that earlier epidemiological findings might be artifactual. Esser (1938) reported that the prevalence of epilepsy in schizophrenia was, in fact, 1.5%; and Yde *et al* (1941) went as far as saying that it was twice that of the general population.

The eventual demise of the biological antagonism hypothesis did not hamper the rapid advance of ECT, particularly as during the early 1940s, it was shown that it worked best in depression.⁶

Meduna's procedure

Following animal research which included injections of camphor in guinea pigs (Meduna, 1934), this Hungarian scientist treated his first patient on 23rd January 1934, and by the end of the year, had treated another 26. Based on this experience, he reported a response to cardiazol of about 66% amongst acute and stuporous patients with schizophrenia - a rate far superior to that shown by the chronic group. He believed that cardiazol acted on the medulla oblongata, and that its convulsant effect was reached at a range of 0.4-0.5 gm, when given intravenously and diluted in a 10% solution. The convulsion usually occurred within 2 seconds of the injection, and lasted anything between 30 to 80 seconds (Meduna, 1937, 1938). By the time he had emigrated to the United States, the antagonism hypothesis had been called into question. Not defeated by this, he proposed that the shock worked at an endocrinological level to re-establish mental 'harmony' in the psychosis (Meduna, 1943).

At least for the first 20 years, ECT did not replace metrazol therapy and both treatments were offered in various centres, often combined. But there were practical problems with metrazol therapy. The commonest were that patients did not fit, or had a fit outside of the intensive care period, or seizures lasted longer than was therapeutically desirable. In the event, it was felt that electricity afforded a better control upon both the timing and duration of seizures, and caused less pre-convulsion fear.

The Italian beginnings of ECT

By 1935, Ugo Cerletti, professor of Neuropathology and Psychiatry in Rome,⁷ became interested in convulsive therapy, and sent one of his assistants to Meduna's department to learn the technique. Then, with the help of Lucio Bini (who is said to have been crucial to the success of the research),⁸ Ferdinando Accornero⁹ and Mario Felici,¹⁰ Cerletti set out to research into the usefulness of electricity for seizure induction. He is said to have learned from observation (and research) at a slaughter-house in Rome that an electric shock through the head given to animals only renders them comatose, and that there was a correlation between the amount of electricity and the behavioural effects.¹¹

There is little point in repeating the oft-told story of this research, and of the first ECT in a human being. Two issues, however, are worth noticing. One concerns surprising discrepancies between the accounts given by Cerletti (1940, 1950; 1956) (Impastato, 1960), who seems to have seen himself as the absolute creator of the treatment, and those by Accornero (1970) and Kalinowsky (Abrams, 1988) who emphasise the contribution of other members of the team, particularly Bini. The crucial contribution by Bini seems to have

been his realisation that what killed about 50% of dogs in Cerletti's earlier experiments was the fact that electrodes were placed axially (head and rectum) and the current passed through their heart (Abrams, 1988, p.29).

The second issue concerns the awareness shown by Cerletti and his team of the ethical implications of their experimental treatment. This is reflected in the painstaking research and animal trials that were undertaken before it was decided to go ahead with the first treatment in human beings.¹²

The first period: 1936-1945

From the historical point of view, the survival and popularity of a treatment is as much a problem as its discovery. This is the case with ECT. By the early 1940s, it was known and used in the USA (Pulver, 1961), Britain (Fleming *et al*, 1939), France (Lapierre & Rondepierre, 1941; Delmas-Marsalet, 1943), Germany (Braunmühl, 1947), and Spain (Gutiérrez *et al*, 1990). Indeed, by 1945, there were already more than 60 research papers on various aspects of the new treatment.

The crucial observation to be made here is that, although *ab initio* ECT was conceptually based on the earlier convulsive therapies, it soon developed a life of its own. By the early 1940s, as the biological antagonism between epilepsy and schizophrenia declined (Kennedy, 1940, p.78), and the first clinical trials showed that ECT was more efficacious in the affective disorders (see below), no one bothered to mention epilepsy any more. Indeed, the early 1940s can be described as a period during which: (a) researchers looked for new scientific basis for ECT; (b) dealt with side-effects, and (c) extended the range of indications. For comparative purposes, these three points will be briefly discussed in relation to some European countries, and then in Great Britain.

The European Continent

France

France was prepared to accept ECT because of earlier reviews supporting the usefulness of other convulsive therapies. Paul Abély (1939), the much respected director at the Villejuif Hospital, published in 1939 a crucial paper on the treatment of dementia praecox with insulin and cardiazol, concluding that both methods were of great theoretical and practical interest, worked in schizophrenia, and might lead to a review of psychiatric concepts. During the same year, in a French journal, Meduna (1939) defended the usefulness of cardiazol in schizophrenia, comparing results in and outside Europe. Interestingly enough, statistical analysis of his data shows that European countries did significantly better than non-European countries, but that the significance disappears when cases with an illness longer than a year are excluded from the analysis (see Table 2).

In general, however, how ECT was to be seen in France depended on ideology and nationalistic sentiment. For example, Claude & Rubenovitch (1940) in their

TABLE 2

<i>Modified from Meduna (1939)</i>			
	European countries	Non-European countries	Stats=X2
Patients (total number)	2326	1751	
remissions	675	397	11.9; P<0.01
Duration of illness < 1 year	793	480	
remissions	398	244	4.2; not signif.

classical text on *Biological Treatments in Psychiatry* expressed some surprise 'at the fact that the treatment was considered new', as it was just a continuation of the work of the Frenchman Stéphane Leduc¹³ from Nantes who 40 years earlier had researched into the provocation of sleep by means of low voltage, alternating currents (Leduc, 1902).¹⁴

Early and enthusiastic sponsors of ECT in France were Lapipe & Rondepierre (1941) who, not to be outdone and with the help of Dr. Bargerton, a physiologist from the Paris Medical School, constructed their own machine which could deliver stimuli with durations of up to 10 seconds, and energy of up to 1,000 milliamps. They also carried out measurements of skull resistance to achieve good stimulus titration. During the presentation of their work at the *Société Médico-Psychologique*, Heuyer intimated that he 'had been informed that the Siemens company from Germany had also become interested in manufacturing a machine'; and Bour reported that he 'had seen the treatment given in England to all manner of cases'. Gouriou cautioned the audience that all the animals treated by Leduc had in fact died, and that it might be safer to continue using cardiazol. Lapipe retorted that Leduc had used a rectangular current of 100 cycles per second and with a duration of minutes, and that their stimulus lasted under a second, and was an alternating sinusoidal current (AMP, 1941, pp.945).

The same year, two other clinical reviews in favour of the technique were published in France. The first was by O.L. Forel (1941) who believed that 'it was time for the new treatment to be evaluated and distinguished between aborted, incomplete and full seizures'. In the latter, there was a tonic period characterised by apnoea lasting between 40 to 60 seconds, and then a clonic phase. Forel reported a therapeutic success for full seizures of about 65% in patients with catatonia, melancholia, and mania and advised that these gains should be consolidated by giving them 'psychotherapy'. Amongst the side-effects, he reported the presence of 'retrograde amnesia', but believed that this was only common amongst the 'impressionable', the 'hypochondriacal', and the 'vindicators'. A few months later, the work of Lamarche *et al* (1941) appeared, reporting ECT in 25 patients and concluding that the treatment worked in all the psychoses, could be combined with insulin coma, caused little anxiety, was cheap, and could be repeated without causing harm. Furthermore, it was safe in the physically ill, agitated, and old.

There was also important debate on the mechanisms of ECT in France. According to the 'diencephalic theory' (Delay, 1950), ECT was a 'harmoniser' acting via modifications in the metabolism of mood. It followed that changes observed in non-affective symptoms such as delusions and hallucinations were secondary to a primary regulation of emotional function. According to a rival

theory, developed from a Jacksonian perspective, symptoms resulted from 'partial dissolutions' and the convulsive therapies (including ECT) caused a total 'dissolution' of brain function. The ensuing 'reconstruction' returned psychological functioning to its normal level (Delmas-Marsalet, 1943). Up to the middle 1940s, and in spite of this theoretical debate, France remained divided as to the usefulness of ECT. In 1945, there were major exchanges at the *Société Médico-Psychologique*, with ECT being defended by Rondepierre, Guiraud, and Minkowski and harshly criticised by Baruk (on the basis of side-effects), Delmas (on low efficacy, hidden by a bias against reporting negative results), Sivadon (on the danger of triggering spontaneous seizures), and Daumezon (on extreme variability of results).¹⁵ In the same year, however, the famous paper by Delay & Maillard (1945) also appeared, reporting that ECT was of clinical use in the treatment of organic delirium.

Germany

German attitudes to ECT during this period were similar to those in France. The leading researchers at the time were Braunmühl (1947), Weitbrecht (1949), and Walter Ritter von Baeyer (1951). Their books are crucially important to understand the arrival and acceptance of ECT in Germany (particularly in the oversensitive climate of the immediate post-war period).

Braunmühl was director of the Eglfing-Haar Hospital and professor at Munich, and had been researching in convulsive therapy, particularly insulin coma, since before the war. In his important book, *Insulinshock und Heilkrampf in der Psychiatrie*, ECT is dealt with in the chapter of convulsive therapies (pp.142-78). A detailed account is given of current variables, side-effects, and both bilateral and unilateral placing of electrodes (p.148). The author recommended Corberi's schema for electricity titration, i.e. changing voltage according to skull resistance, but keeping the same duration of stimuli. He also offered a classification and criteria to differentiate between abortive, incomplete, and complete seizures, and described *Schemas* for the administration of a *Blockmethode* treatment, i.e. for convulsions induced in successive days (pp.182-3).

In his book on biological treatments for schizophrenia, Hans Jörg Weitbrecht (1949) dealt with ECT techniques, and discussed its explanatory hypotheses, particularly von Baeyer's view that ECT worked temporarily by 'abolishing pathological experiences' (*Erlebnisse*) and hence only postponing the onset of the disease. Weitbrecht argued that such a mechanism was unintelligible in terms of what was known about brain functioning, and that it was more likely that ECT actually corrected an unknown pathological process (pp.14-15).

Fully dedicated to the convulsive therapies, Von Baeyer's book (1951) included a special section on ECT and undertook a more detailed survey of the foreign literature than hitherto had been the case in Germany. As mentioned above, he believed that ECT caused a veritable 'organic disorder' which postponed the development of the psychosis. Consequently, he agreed with the so-called *Blockmethode* (as described by Braunmühl, 1947), since it accelerated 'organic disorganisation'.

Great Britain

From the start, ECT found firm sponsors in Britain. For example, G.W.T.H. Fleming, an influential figure in the Royal Medico-Psychological Association and F. Golla, director of the Burden Neurological Institute, wrote favourably about the new treatment and Grey Walter gave it scientific respectability by exploring its electroencephalographic features. As mentioned above, on 30th December 1939, these three men published an influential article in *The Lancet* dealing with what during that early period mattered most, its technical aspects. They said that it was: 'not proposed to discuss here the therapeutic results of electroconvulsive therapy; it must stand or fall by the ultimate verdict on shock therapy in general. From the technical point of view there can be no doubt that the electrical method is greatly superior to any hitherto employed for the production of severe convulsions. For the operator, only a small amount of training is necessary' (Fleming *et al.*, 1939, p.1354). After observing 75 shocks given to 5 subjects with schizophrenia, they reported that 'no untoward results were observed . . . the claims of Cerletti and Bini are confirmed; the method is technically effective, simple, and safe and arouses no fear or hostility in the patients' (p.1355).

A year later, at a meeting of the psychiatry section of the Royal Society of Medicine, Shipley & McGregor (1940) endorsed the treatment from the clinical point of view: ECT did not produce any of the side-effects of cardiazol (fear, vomiting, confusion, thrombosis, patients struggling), was fully controllable, could be combined with cardiazol, was useful as a maintenance treatment, and in 200 treatments no fractures were observed.

Then appeared the important review by Freudenberg (1941) on the 'curability' of mental disorder by ECT. This German émigré, then working at Moorcroft House, in Middlesex, introduced his paper with an imaginative analysis of the concept of 'curability' in the context of schizophrenia, and explored both 'favourable' factors such as acute onset, short duration of illness, pyknic or athletic constitution, and cyclothymia, and 'negative factors' such as insidious onset, long duration of illness, dysplastic or leptosome constitution, schizothymy, and 'process' symptoms. He concluded that no individual factor could yet predict the outcome, that the affective psychoses responded better to shock therapy, and that insulin and convulsive therapy (including ECT) should be considered as complementary treatments.

Even more influential during this period was the paper by Hemphill & Walter (1941) reporting the treatment with ECT of over 200 in- and out-patients. It included norms to choose the right method of administration, a table to calculate the correlation between strength and duration of electrical stimulus (p.261), an assessment of the factors governing seizure duration, and even the proposal that in ideal conditions, seizure duration should be around 45 seconds (range 25-65 seconds). In regard to the relationship between efficacy and diagnosis, they concluded that: 'manic depressive and involutional melancholics respond best to treatment' (p.274). This confirmed the report by Borgarello (1939) that ECT improved 50% of 24 manic-depressives but only 10% of 56 schizophrenics, as well as the report by Dawson (1939) that pre-ECT convulsive therapies were also more efficacious in the affective psychoses.

Early British work on ECT is also characterised by preoccupation with its clinical

indications and with side-effects. J.C. Batt (1943) published his trial of ECT in 100 cases of depressive psychosis including manic-depressives, 'menopausal, and senile affective psychoses'. The author concluded that although about 90% of depressions 'reacted favourably to electrically induced convulsions . . . 13 per cent of all cases relapsed' (p.294). He was, however, unable to identify a pattern of symptoms that might discriminate between responders and non-responders.¹⁶ More optimistically, O.W.S. Fitzgerald (1943) reported that the presence of premorbid 'melancholic trends' in the personality augured a good response to ECT.

Others sought to assess the efficacy of ECT by comparing matched samples with and without ECT. Penrose & Marr (1943) reported that 'fewer shock treated cases remained on the hospital books than are expected from considerations of the control sample' (p.380). Equally imaginative was the work of N.P. Moore (1943), who evaluated maintenance ECT in 45 cases suffering from a variety of psychoses:

chronic psychotics whose behaviour endangered their health, constituted a serious nursing problem, or whose mental state was one of misery were treated with electrically induced convulsions repeated at intervals, with the object of maintaining the improvement achieved after an initial course of treatment or of cutting short a particular phase of illness . . . all cases responded favourably except eleven of the schizophrenic group . . . in some cases treatment has been in progress for over two years . . . clinical observation shows no appreciable deterioration in personality or intelligence as a result of continued therapy. (p.268)

In spite of early optimism about ECT causing only minor side-effects, it soon became clear that fractures were a real problem. Thus, Samuel (1943) reported the worrying trend that in 420 consecutive cases, there had been 12 fractures (2.8%) (fractures of the spine 5, of the humerus 2, simple, of the right humerus 1, of femoral neck 5, and pelvis 1). As a solution, Shorvon & Shorvon (1943) suggested that spinal anaesthesia might be superior to injections of curare, of concentrated magnesium sulphate solution, or of beta-erythroidin hydrochloride. These authors reported that in cases with high risk for fractures, the spinal injection of stovaine (which caused mild meningitic reactions) was justified.

The aftermath

There is little doubt that the most interesting and imaginative research on ECT occurred in the period 1938-1945 when side-effects, clinical indications, maintenance therapy, and the use of modifications to deal with fractures, fear, and excessive salivation were investigated. It became clear that manic-depressive psychosis and not schizophrenia was the main indication for ECT, that indicators for positive response were elusive and difficult to identify, and that unilateral placing of electrodes had certain advantages (Braunmühl, 1947, p.148). There was also much work on mechanisms and Gordon (1948) was able to identify 27 biological and 23 psychological theoretical accounts!

Only the question of seizure duration remained extant. Hemphill & Walter (1941) had attempted to solve it, but it was Finner (1954) from Yale University

who showed in the first systematic study that (given the same stimulus), women and older subjects have shorter seizures, and that duration shortens in the later shocks of a series. Work since then can be considered as an effort to develop some of these important ideas. In the meantime, ECT remains one of the most efficacious treatments in psychiatry.

Notes

- 1 Fleming was at the time the editor of the *Journal of Mental Science*, after a successful career at the Maudsley Hospital (see chapter by Bird, this volume), Golla had just been appointed to the directorship of the Burden Institute, and Grey Walter, a brilliant neurophysiologist, had recently moved from Aldrian's laboratory in Cambridge to Bristol.
- 2 Some include insulin therapy and even psychosurgery as context for the history of ECT (e.g., Fink, 1979, pp.8-10). This is too wide and blurs important conceptual distinctions.
- 3 However interesting, the history the use of electricity in medicine and psychiatry is surprisingly not of direct relevance to the history of ECT. See, for example, Stainbrook (1948), Cossa (1948), Harms (1955), Schneck (1959), Brandon, (1981), Azouvi (1986) and Beveridge & Renvoize (1988). The report that in 1804 Aldini 'discovered an association' between an electrically induced convulsion and melancholia (Bourguignon, 1964) does not run counter to this statement as the definition of 'melancholia' in 1804 was very different from current depression (Berrios, 1995a). In fact, John Aldini (1762-1834), a nephew of Galvani, was a professor of Physics who dedicated his life to the study of the effects of electricity, including those on medical practice. Electrotherapy has a long history, but it is unlikely that it can be meaningfully linked to the history of ECT (Mitjavila, no-date).
- 4 Von Meduna (1896-1964) was born in Hungary and completed his medical studies at the Royal Clinical School of Budapest in 1921. He started his academic career three years later as an assistant professor at the Neurological Institute in the same city and in 1927 became associate professor of psychiatry. In 1933, he was appointed consultant to the Leopold Field hospital. The Nazi threat led him to emigrate in 1939 to the USA, where he continued his career at the University of Illinois. At the Neurological Institute, he worked under the great Karl Schaffer on the distribution and type of neuroglia in the cortex of subjects with epilepsy and schizophrenia. He is credited with the development and implementation of cardiazol therapy. Later, he also developed the interesting clinical notion of 'oneirophrenia' (Meduna, 1950).
- 5 Much in the same way in which the relationship is conceived of nowadays; see: Garimond (1878), Siemens (1879), and Meeus (1908).
- 6 Malzberg (1943) reported that 491 cases of dementia praecox did better on insulin treatment than ECT, and that 33% of 142 manic-depressives, and 23% of 85 involutional patients did better on ECT. The author concluded that ECT was more effective in the manic-depressive and involutional groups than in dementia praecox; Smith *et al* (1942) found likewise.
- 7 The son of an agricultural engineer, Ugo Cerletti was born at Conegliano Veneto, Italy, on 26th September 1877 and trained as a physician at Rome and Turin. He did his neuropsychiatric training in Paris under Pierre Marie and Ernest Dupré, and at Heidelberg and Munich under Kraepelin, Nissl, and Alzheimer. During the First World War, he is said to have invented a white camouflage for the Alpine troops, and also a delayed time fuse for the rifle. He became a professor in Rome in 1935, retired in 1948, and died on 25th July 1963 (Breathnach, 1990).
- 8 Lucio Bini was born on 18th September 1908, and when at age 30, he started his collaboration with Cerletti, he had not yet trained as a psychiatrist. He was soon to do so and in the event was senior author of one of the leading Italian textbooks of psychiatry (Bini & Bazzi, 1954). He also wrote an important (and little known) monograph on dementia (Bini, 1948). At the time of his untimely death in 1964, he was a Clinic director at San Camillo Hospital in Rome. There is some evidence that Cerletti tried to play down Bini's contribution. In 1950, for example, he stated that he was 'only a technician' (Impastato, 1960) and Lothar Kalinowsky once confided that: 'Cerletti was very angry after the war that the method was called Cerletti-Bini, or even Bini-Cerletti; he did his best to prevent Bini's academic advancement, and as a result, Bini never became a professor' (Abrams, 1988, p.31). This damning view, expressed by someone who actually worked in Cerletti's

- clinic and knew those involved must be taken seriously.
- 9 Ferdinando Accornero (1910-1985) was the third collaborator in the ECT project and was to write the most useful account of the events which surrounded the use of ECT in humans (Accornero, 1970).
 - 10 Much less is known on the fourth member of the team (Endler, 1988)
 - 11 Cerletti & Bini's (1938) *post-hoc* narrative must be considered as a reconstruction (in Lakatos's sense): When 'Cardiazol-induced convulsive therapy appeared on the scene, the authors thought *immediately* of using an electric current to achieve the same results' (p.260).
 - 12 It also explains the fact that little is known about the first treatment, which is said to have been carried out in secrecy. What is celebrated is actually the second treatment.
 - 13 Lapipe & Rondepierre (1941) also believed that Cerletti 'had inspired himself with the work of Leduc' (p.87).
 - 14 Claude & Rubenovitch (1940) also quote the work of Denier and Kalendaroff (whose real objective was to induce 'sleep by means of low voltage electricity and avoid seizures'). This suggests that Claude & Rubenovitch believed that the aim of ECT was actually to cause temporary anaesthesia!
 - 15 See minutes of S.M.P. in *Annales Médico Psychologiques*, (AMP, 1945).
 - 16 This topic was greatly to exercise British psychiatrists during the 1950s. See for example, findings by M. Roth (1951) that 'an atypical EEG is associated with a poor therapeutic response' (p.278), efforts by R. Hobson (1953) to identify predictors of good response, and Thorpe's review (1962) on the use of the Funkenstein Test, the sedation-threshold test, the amyntal test, and psychological tests.

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2 British contributions on the eating disorders: a historical perspective

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Specialist clinical interest in disordered eating patterns has accelerated recently, accompanied by important contributions on the historical dimension by both medical and non-medical researchers, (Bell, 1985; Beumont, 1991; Brumberg, 1988; Bynum, 1988; Habermas, 1994; Schwartz, 1986; Vandereycken & Van Deth, 1994). Nevertheless, many areas remain contentious and under-researched. There is considerable scope, for example, to broaden the historical canvas by relating the views and practice of British physicians and psychiatrists treating patients with eating pathology to those of their European and American counterparts. This chapter, therefore, examines the British contribution, against the background of contemporaneous European and American developments, particularly during the nineteenth and early twentieth centuries.

Current diagnostic classification systems, DSM-IV (1994) and ICD-10 (1992) recognise, with some important variations in status and affiliation, four eating disorders; anorexia nervosa, bulimia nervosa, rumination disorder, and pica (Parry-Jones & Parry-Jones, 1994). In this chapter, each disorder will be discussed separately, incorporating a short account of terminology and pre-nineteenth century presentation. Investigation of nineteenth and twentieth century developments included screening the *Medical Annual*, 1883-1983, to assess the frequency of references to each disorder. This journal was selected since its contents were claimed to reflect subjects concerning which reference was 'most frequently' required, and to incorporate 'the principal facts in Medicine, Surgery and Therapeutics' which had appeared in some 150 British and Foreign Medical Journals during the preceding year (Editorial, 1883). Perhaps more importantly, when eating disorders were treated in multiple settings, this rudimentary review journal aimed at a broad professional readership. To estimate the relative importance of the four disorders during the early twentieth century, the contents of nine editions of a standard British psychiatric textbook (Henderson & Gillespie, 1927-1962) were screened for entries. These searches complemented information from the authors' existing data base of cases and secondary sources on the history of eating disorders.

Anorexia and anorexia nervosa

Of Greek derivation, *anorexia* or *fastidium* in classical and medieval Latin texts implied lack of appetite, or food loathing. *Anorexia* (*anorexie/anorexy*) appeared in English sources in the late sixteenth century and, as a symptom in many disorders, has remained in continuous medical usage. Over the centuries, self-starvation has presented in many guises during transition from a predominantly religious and ascetic mode to the acquisition of medical syndromal status as anorexia nervosa. Fasting manifestations as integral parts of religious experience occurred in many cultures, particularly during the Middle Ages. The early modern period, with its sporadic reports of miraculous fasting girls and waves of chlorotic, hysterical, and neurasthenic female patients – many of whose illnesses incorporated symptoms of self-denial, perversities of appetite, and food refusal – demonstrate progressive secularisation and medicalisation of fasting behaviour. Voluntary starvation in the context of an adequate food supply has always exerted an emotive and manipulative impact on onlookers, leading to the chronicling of many dramatic instances of apparently inexplicable abstinence (Parry-Jones, W.Ll. & Parry-Jones, B., 1995). A collection of 360 cases, covering the years 1500-1936, derived chiefly from printed sources, of voluntary self-starvation or sustained low weight, 179 of which incorporated abnormal attitudes to food, eating, or weight provided the clinical basis for this section on anorexia (Parry-Jones, W.Ll., 1985; Parry-Jones & Parry-Jones, unpublished data).

Britain

Despite sporadic earlier reports of prolonged abstinence, such as the 12-month fast of the Overhaddon girl (Reynolds, 1669), the treatment of two teenage cases of 'nervous consumption' by Morton (1689) remains a worthy landmark in the early history of medical involvement in the phenomenon of self-starvation. Describing Miss Duke, aged 18, as 'a Skeleton only clad with skin', Morton recorded menstrual suppression, mental 'cares and passions', diminished appetite, over-studying, and a wish to cease treatment, so illness could take its course. Her case, which terminated fatally, in the absence of fever, cough, or pulmonary failure, has been the subject of many comparisons with the clinical features of anorexia nervosa. Although other British reports of prolonged food refusal were published during the seventeenth and eighteenth centuries, these were chiefly news items and not usually of medical origin. Exceptions were the detailed medical descriptions of two fatal abstentions, by a 16 year-old girl (Eccles, 1744) and a studious young man (Willan, 1790) as well as the near-fatal case of a young woman, who, believing herself too fat, dieted on pickles and vinegar (de Valangin, 1768). Nineteenth-century reports became predominantly medical, since practitioners were increasingly expected to explain fasting behaviour and to verify the genuineness of survival without food, sometimes with tragic results, as in the case of Sarah Jacob (Fowler, 1871). Works on diseases of women (Hall, 1830; Laycock, 1840) included references to food restriction and to consumption of improper foods or items obtained secretly, or by stealing, among 'hysterical' young females. Lewes (1859) directly associated reduced intake and consumption of vinegar with fears of fatness in

young girls, advising that they should 'never pine for graceful slimness' if this was prejudicial to health. It was against this background of fairly common food abstinence by pubertal girls and growing interest in the dietetic care of patients that Gull made his original case for diagnostic accuracy when confronted by 'young women emaciated to the last degree through hysteric aepsia' (Gull, 1868), on which was based his subsequent claim to be the first to describe the 'new' disorder. In October 1873, Gull, having referred to Lasègue's earlier paper on hysterical anorexia as 'confirmatory' of his own views, re-named the condition anorexia hysterica, (from 1874, anorexia nervosa), emphasising that the appetite disorder was not aepsia, but due to a morbid mental state (Gull, 1873).

The ensuing discussion, during that particular meeting of the Clinical Society of London, demonstrated that Gull was not the only British practitioner familiar with this form of food refusal, and there was general agreement about moral management, separation from family and friends during treatment, and supervised re-feeding. Treatment was given privately at home, in hospitals, and in complete isolation in so-called 'hysterical homes'. The latter provided a discreet venue for middle-class girls, but were criticised by Hovell (1888) as unsuccessful and by Myrtle (1888) as unnecessary and often economically unattainable for patients' families. Alienists, such as Campbell (1878), emphasised the effectiveness and economy of asylum admission for forced feeding of cases of 'hysterical insanity' – his term for fasting girls. Cases of hysterical anorexia were published by Wilks (1878) and Fenwick (1880), but neither they, nor Gull, despite his alienist training, showed any awareness of weight preoccupation in their patients. Other practitioners, however, appear to have been more perceptive. Fothergill (1874) noted that girls, 'alarmed at their plumpness . . . upon whom the dread of being fat weighs like an incubus,' resorted to vinegar to ruin digestion. A *Lancet* editorial (1880) referred to the 'morbid dread of fat which has in recent years become fashionable', and Clark (1887), discussing chlorosis, described the impact of menarche on a girl's habits and thoughts. 'She becomes self-conscious . . . thinks of her appearance and tightens her waist. Afraid of getting fat, she stints herself in food, and eats . . . only dainty things.' Perhaps some explanation for the apparent lack of perception of female weight concern can be found in criticisms of contemporary practice voiced by Reynolds (1871); 'for some ten years past, we have practically ignored what our patients say to us about their feelings, and have based our judgements and therapeutics upon our direct observation of the phenomena of disease. Is it not the "fashion" . . . to direct attention almost exclusively to what has been termed "objective" symptoms, and to pass over as valueless, or nearly valueless, all the statements that patients make, and indeed all that group of symptoms which has been termed "subjective"'. This situation, probably compounded by Victorian female subservience to a powerful male medical hierarchy, could have obscured temporarily the existence of any preoccupations about weight and shape, such as are central to the modern syndrome of anorexia nervosa.

In 1888, as Silverman (1988) has pointed out, 11 articles on anorexia nervosa were published within 63 days in *The Lancet* (in contrast with two, concerning the exhibition of a professional faster, in corresponding numbers of the *British Medical Journal*). Most notable among these were Gull's final contribution, the case study of Miss K.R., whose illness he attributed to 'perversion of the ego,' and an article by Playfair (1888a), suggesting that the term 'anorexia nervosa'

should be broadened to 'neurasthenia' to cover cases where loss of appetite was not the main symptom. As the leading British exponent of the American 'Weir Mitchell' treatment, Playfair promoted its regime of isolation, bedrest, massage, faradisation, and over-feeding. Voluntary starvation continued to intrigue the medical establishment, although suspicions of imposture were readily aroused in a century which had witnessed the unmasking of feigned fasters, such as Ann Moore (Henderson, 1813) and Ann Riding (Editorial, 1871). Descriptive terminology was confusing and diagnosis remained a grey area. Indeed, Dowse (1881) claimed that past, and to some extent current cases of anorexia nervosa were misdiagnosed as 'consumption, catarrh of the stomach, indigestion and cancer', and that some deaths from inanition and starvation could have been prevented by continuous feeding. He viewed food abstainers as 'borderland' cases, verging on insanity, yet clearly differentiated from cases of melancholia with anorexia so frequently seen in asylums. Playfair (1888b) similarly dubbed these 'borderland' cases 'a little cracky' and referred to strong pressures by relatives, fearful of the stigma of insanity, to class them as 'hysterical' rather than 'mental'. Further cases of food refusal, including two fatalities (Stephens, 1895; Marshall, 1895), were published in the closing years of the century, but their overall incidence remains difficult to estimate. Goodhart (1892) stated that severe cases, like those of Gull, were 'certainly rare', but that 'the same disease exactly, but not reaching anything like the same extent, may be seen almost daily by anyone in his own practice'. Later, Allbutt (1898), who treated many 'chlorotic' girls, referred to the prevailing 'panic fear of obesity,' which led to reduced intake and widespread use of antidotes such as vinegar. In a separate section on anorexia nervosa, Allbutt (1897) characterised the patient as an ascetic, noting her hyperactivity, dislike of meat, and her capacity to disrupt family meals. Gee (1907) reintroduced the term 'nervous atrophy' (Whytt, 1767). He believed that anorexia nervosa, which was allied to and could terminate in insanity, arose from a craving for sympathy. Patients were preponderantly post-pubertal females, but he had seen the disorder in a boy aged 11 and in younger children, including a girl of three. During the nineteenth century, reports of anorexia nervosa in pre-pubertal girls were rare and the 7 ½ year-old, weighing 29 pounds, described by Collins (1894) was unusual. In the first quarter of the twentieth century, however, further discussions of this disorder in young children were published in Britain and in the USA (Forchheimer, 1907; Carr, 1911; Cameron, 1912; Atkinson, 1912; Myers, 1924). The latter described food refusal and weight loss in three girls aged under 5 who recovered in nursing homes away from 'neurotic family influences'. Opinion was divided whether anorexia nervosa could occur in children, with Still (1924) disagreeing, and Crookshank (Brown *et al*, 1931) concurring – even conjecturing that marasmus in babies might provide a precocious example. During the 1960s, the possibility of pre-pubertal onset was confirmed by the description of children aged 7 years and upward in a study by Blitzer *et al*. (1961) and of several 10-12 year-olds in studies by Lesser *et al*. (1960) and Warren (1968). More recently, there has been increased reporting of childhood anorexia in Britain (Treasure & Thompson, 1988; Russell, 1992; Lask & Bryant-Waugh, 1993).

Acknowledgement of the importance of anorexia nervosa as a twentieth-century topic is supported not only by its presentation in successive editions of Henderson & Gillespie (1927-1962), but also by the incorporation of 20 key

references (1931-1981) to anorexia nervosa and 15 (1930-1957) to Simmonds' disease in the *Medical Annual*. These related chiefly to the period of diagnostic confusion following the description by Simmonds (1914) of a fatal female case of pituitary cachexia, some of whose clinical features (amenorrhoea, low basal metabolic rate, and low temperature) resembled anorexia nervosa. A process of somatisation of the latter disorder, during which psychological factors were largely overlooked, occurred, chiefly in German-speaking countries. In British literature, occasional fatal cases of anorexia nervosa continued to be reported (eg. Elliott, 1914; Conybeare, 1930) and 'misleading reports' in newspapers surrounding the death in 1931 of an 18 year-old girl from self-starvation, claimed by her physician to be 'an isolated phenomenon' generated a heated response (Brown *et al*, 1931). Four physicians and a neurologist gave personal accounts of treating anorexics, prefacing these with an attack on the prevailing level of ignorance; 'But is it not ironical . . . that not only do young girls still pass to their death from Anorexia Nervosa – even in the Metropolis – with the nature of their disorder recognised by few, and its origins by fewer still, but that literally numberless lives . . . are crystallized along lines of neurosis and worse for lack of appreciation, by doctors and by parents, of the factors that *do* lie at the foundations of Anorexia Nervosa?' (Brown *et al*, 1931).

Nevertheless, some practitioners, such as Venables (1930), who described the successful treatment of nine anorexic patients at Guy's, were more optimistic about the outcome. Allison & Picton Davis (1931) who developed, in a private hospital setting, an idiosyncratic treatment involving periodic fasts for cases of 'functional anorexia,' reported no fatalities, while Ross (1936) utilised a form of 'Weir Mitchell' treatment at the Tavistock Clinic. He claimed that it was easy to fatten a patient, but emphasised the frequency of relapse if mental change had not been effected, and identified a group of severe borderline cases, one of which terminated fatally, as 'anorexia psychotica.' The two most influential British figures were Ryle and Sheldon; the former was a dedicated exponent of Gull's original views (Ryle, 1936), while Sheldon, influenced partially by the endocrinological lobby, believed some anorexics had a degree of pituitary abnormality and made a case for 'functional Simmonds' disorder' – a 'pituitary 'blackout' of psychological origin' (Sheldon, 1937). Ryle considered that slimming on account of adolescent plumpness ranked second among psychological causes of anorexia nervosa, and Sheldon interpreted the high incidence of pre-anorexic stoutness to be supportive of his idea of mild pituitary derangement, suggesting that 'the infantility which often characterised the psychological background' might be 'the counterpart of an actual endocrine infantility'. Brown (1937) believed anorexia nervosa to be increasing, citing the fashionable cult of slimness, Peter Pan complexes, mother-daughter tensions, and fears of 'going out into a world fiercely competitive at work and games' as causative. Both anorexia nervosa as a latent form of dementia praecox, already postulated in France (Dubois, 1913) and considered by Brown (1931), and the differential diagnosis between anorexia and Simmonds' disease were investigated by Nicholle (1938). She viewed anorexia nervosa as an identifiable highlight in a series of varied conditions associated with dementia praecox on the one hand and endocrine disorder on the other, while Reiss (1943) proposed the term 'cerebral' pituitary cachexia for an emaciated anorexic patient whose rapid onset of obesity he attributed to a swing from hypofunction to pathological hyperactivity of the pituitary. Confusion

between anorexia nervosa and Simmonds' disease, although it never reached major proportions in Britain, was finally dispelled by the research of Sheehan on hypopituitarism (Sheehan, 1948; Sheehan & Summers, 1949). Nevertheless, as Kay & Leigh (1952) observed, the position of anorexia nervosa in psychiatric semiology remained uncertain. It was still unclear whether it was a neurosis or a psychosis, whether it should be allied to schizophrenia or manic-depressive disorder, or if it constituted an entity in its own right. In Kay & Leigh's important study of 38 anorexic patients, it was reported that 10 expressed abhorrence for fat people and for the idea of becoming fat. Weight concern, therefore, was no longer an undercover issue. Williams (1958) provoked a furore by declaring anorexia nervosa to be a somatic disorder, requiring intubation rather than psychotherapy, producing angry ripostes from Sim & Tibbetts (1958) and from Stafford-Clark (1958). The latter pointed out that successful treatment using psychological approaches was carried out, without intubation, by family doctors, psychiatrists, physicians, and in child guidance clinics. During the 'Twiggy' era of the 1960s, when slimness reached exaggerated levels, two new treatments for anorexia nervosa were introduced with some success – leucotomy in chronic cases (Dally & Sargant, 1960) and chlorpromazine with modified insulin (Dally & Sargant, 1966). At about the same period, Russell (1965) investigated metabolic aspects, testing the hypothesis that it was a disorder of hypothalamic function, and Crisp (1965) put forward the view that the emotional conflict of female anorexics stemmed from ambivalence towards the female sexual role and loss of parental support, the illness constituting an avoidance response to overwhelming emotional conflicts, which required the psychotherapeutic treatment of both patient and family. Increasingly, anorexia nervosa was becoming the concern of psychiatrists, rather than physicians, but, as the title of a paper by Crisp (1970) indicated, uncertainties still persisted whether it constituted a feeding disorder, nervous malnutrition, or weight phobia.

Europe

Although Lasègue has been conceded priority over Gull in describing 'anorexie hystérique' in 1873 (Silverman, 1992; Vandereycken & Van Deth, 1989), two fellow Frenchmen, Briquet (1859) and more importantly Marcé (1860), had recorded earlier examples of female food refusal. The latter attributed the condition to 'a delirious idea', claiming that the emaciated patients were not dyspeptic but 'deranged'. Lasègue's composite account of eight anorexic cases similarly acknowledged psychological implications and problematic family responses. French interest in anorexia nervosa persisted during the late nineteenth century, revealing considerable familiarity with British observations. The descriptive term 'mentale' commonly displaced 'hystérique', in recognition of the absence of the usual signs of hysteria. Charcot (1889), like Gull, advocated parental separation during treatment and demonstrated the efficacy of strong mastery in his management of the refractory Angoulême anorexic. Charcot's entry on anorexia nervosa in Tuke's *Dictionary* (1892) incorporated his personal observation that food-refusers were often 'strongly impressed with the fear of obesity', a fact corroborated by Féré (1892), whose emaciated young patient concealed a tight linen sash against her skin. Self-perception of fatness was noted

also by Wallet (1892) in a 12 year-old girl who drank vinegar. French authors, therefore, consistently articulated the connection between food abstinence and fear of fat during the 1890s. La Tourette (1895) distinguished between primary, 'mental' anorexia of hysteric origin and secondary, 'gastric' anorexia, involving oesophageal spasm, and Dubois (1913) presented a case of mental anorexia as a precursor of dementia praecox. Déjerine & Gauckler (1915) described mental anorexia as a purely psychic disorder 'of frequent occurrence', whose onset was sometimes due to 'coquetry'. It could be fatal in chronicity, tuberculosis commonly supervening. Early twentieth-century themes included viewing tardive mental anorexia as a form of suicide (Nathan, 1928) and increasing awareness of the *idée fixe* of growing thin prevailing among marriageable females (Souques, 1925; Cornil & Schachter, 1939). The latter considered the diagnostic implications of Simmonds' disease, and noted that prominent British authors refuted the glandular origin of mental anorexia. A later contribution (Cornil *et al.*, 1945) comprised detailed discussion of the differential diagnosis, claiming that anorexia nervosa was frequently precipitated by psychosexual shock and, although an uncommon condition, was much less rare than Simmonds' disease. Poisson-Quinton (1943) commented on the increase in the 'curious psycho-physical disease', mental anorexia, among young women, even during the food restrictions of wartime, presuming this to be in response to the 'psychic trauma, emotional shocks and exceptional anxieties' experienced by civilians. The preceding of mental anorexia by a bulimic phase or by obesity, and cyclical variation between anorexia and bulimia, the former characterised by a sense of well-being and power, the latter by feelings of isolation, timidity, and sadness, constituted an important observation by Plichet (1958).

Despite the fact that German sources contain classic cases of hysterical fasting girls from the sixteenth century onwards, acceptance of a psychological basis for anorexia nervosa was not widespread in Germany until the mid-twentieth century. Soltmann (1894), who described some early cases, stated that the views of Gull and Lasègue had not been publicised in German texts, and that different terms, 'anorexia cerebialis' and 'central nutrition neurosis', were applied. He believed the source of the anorexia was the brain and depressive psychic influences. The single, most important influence to emerge from Germany was the description (1914) of a fatal case of total necrosis of the anterior pituitary, later known as Simmonds' disease, in recognition of its discovery by the Hamburg pathologist. Until 1949, there was widespread misdiagnosis in Germany of cases of anorexia nervosa as Simmonds' disease and the psychological basis of the former became obscured in many European countries and in the USA by endocrinological attributions and treatments. In 1941, Wissler (cited in Thomä, 1967) first suggested the term '*pubertätsmagersucht*' to differentiate pubertal emaciation from Simmonds' disease, and by the 1950s, anorexia nervosa acquired separate identification. Thomä (1967) conducted a detailed clinical survey of 30 anorexic patients, utilising psychoanalysis in treatment. Meyer (1971) recorded an increasing incidence and suggested that this was related to female emancipation and the greater number of professional women as mothers. His examples included chronic cases and others precipitated by psychic trauma, and he noted severe anorexia as a prodromal stage in schizophrenia and depression. Precipitating factors included teasing about adolescent plumpness, refusal to grow up, maternal domination, disturbance of body image, asceticism and

repudiation of sexuality. Surveying German-language descriptions of anorexia nervosa, 1900-1945, Habermas (1992b) related its prolonged confusion with Simmonds' disease chiefly to the holistic ideal of psychosomatic medicine during the 1930s.

Two Italian fatalities, described by Brugnoli in 1875, were reviewed retrospectively by Habermas (1992a), since they presented 'a rare link between religiously-inspired forms of extreme fasting and the secular forms . . . identified by medical writers as anorexia nervosa'. Later, the Italian psychiatrist Palazzoli (1985) interpreted anorexia nervosa as a syndrome of affluent society, attributing its increase during the 1960s to fashionable pressures for thinness. The rarity of anorexia nervosa in Russia was referred to in an account (Kissel, 1894), published in a French medical journal, of a Moscow girl who became ashamed of eating, stopped all intake, but was cured after four months' segregation from her family. In Austria, Freud (1918) acknowledged the well-known neurosis in girls 'which occurs . . . at the time of puberty or soon afterwards, and which expresses aversion to sexuality by means of anorexia'. His earlier writings defined anorexia nervosa as a nutritional neurosis, parallel to melancholia, occurring when sexuality was undeveloped. Faltus (1986) reported that 'mental anorexia', occurring mainly in young girls and having similarities with manic-depressive psychosis, was first described in Czechoslovakia in 1946 and that its incidence was increasing. In Denmark, as in Germany, anorexia nervosa was incorrectly diagnosed as a purely somatic disorder during the early twentieth century (Tolstrup, 1990), but reconsigned to a psychiatric context during the 1940s. Limited acceptance of eating disorders in Norway fostered embarrassed concealment by sufferers; sportswomen and schoolgirls were affected principally, and causation was attributed to genetic predisposition triggered by cosmetic dieting, together with psychological and social factors (Michaelsen, 1990).

USA

Although anorexia featured in an early American medical encyclopaedia (Hays, 1836) as a symptom and 'not properly a disease', and sitomania, discussed by Chipley (1860), included a group of hysterical cases in which 'a morbid desire for notoriety' led to protracted abstinence, discussion of anorexia nervosa remained limited in America before the twentieth century (Vandereycken & Lowenkopf, 1990). Occasional investigations of alleged fasters were reported in medical journals (Whiting, 1859; Hertzog & DeLong, 1890). Hammond (1876 & 1879), despite extensive investigation of hysterical fasting girls, never referred to a possible diagnosis of anorexia nervosa, nor was the term employed by Mitchell (1888), many of whose neurasthenic female patients displayed emaciation and reduced intake. Osler's text-book of medicine (1892), however, included a fatal case of anorexia nervosa at a body weight of 49 pounds, and Lloyd (1893) published an account of hysterical tremor and hysterical anorexia in a 26 year-old Pennsylvanian woman. By 1898, Gould & Pyle's encyclopaedia of medical curiosities incorporated, under fasting, a significant entry on anorexia nervosa including a reference to one of Gull's original patients. Sustained interest in the disorder was shown in America throughout the twentieth century. Greene's *Medical Diagnosis* (1922) defined anorexia nervosa as 'absolute loss

of appetite . . . abhorrence and prompt ejection or rejection of all foods'; conceding that it was rare, but by no means a clinical curiosity. Treatment comprised the Anglo-French synthesis of rest, isolation, forced feeding, and firm medical and nursing control. Two of the most important early American papers were by Berkman (1930), who published details of 117 anorexic patients at the Mayo Clinic, 1917-1929, and Clow (1932), who observed that sufferers were usually women 'in an environment which tends to increase their interest in themselves and the value they place on their importance to society'; he suggested possible benefits from vitamin B and insulin therapy. Richardson's paper (1939) discussed the problems of distinguishing anorexia nervosa from Simmonds' disease, which arose from 'too specialised an approach, whether the emphasis is on the physical or on the mental aspect'. He described six cases, all of which showed strong affinities to Simmonds' cachexia but turned out to be anorexia nervosa, including that of a 16 year-old girl, who dieted because she abhorred fat people and believed that no boy cared for a fat girl, and another patient who induced vomiting for weight control. Escamilla's monumental review (1942) of 595 cases of Simmonds' disease and anorexia nervosa systematically clarified the differential diagnosis. Subsequently, in a predominantly psychoanalytic phase, some small case series were published (eg. Small & Milhorat, 1944; Nemiah, 1950), responding to the paucity of clinical material and providing increasing evidence of the psychological origins of the disorder. This culminated in the influential work of Bruch, in the 1960s and 1970s. Bruch (1966) regarded a pervasive sense of ineffectiveness and disturbed body image as fundamental. Although she was the first to discuss the latter in relation to anorexic patients, this distortion had been identified previously in other neuropathological and psychopathological conditions (eg. Lhermitte, 1939). Bruch (1978) categorised the condition as a disorder of affluent societies, increasing rapidly in response to psychosocial factors, particularly the emphasis that fashion placed on slimness, and the growing sexual and professional freedom of young women. Recognition of this higher profile of eating disorders was acknowledged by their inclusion as a distinct grouping in DSM-III (APA, 1980).

Bulimia and bulimia nervosa

Bulimia was derived from the Greek *bous*, ox and *limos* hunger, the medieval Latin forms *bulimus* and *bolismus* and the middle French *bolisme*, all of which indicate abnormally heightened hunger, culminating in ingestion of an unusually large volume of food. Its usage, implying extreme hunger accompanied by weakness or faintness, is traceable in early Greek and Latin texts and its first occurrence in English has been traced to a late fourteenth century translation of Bartholomaeus Anglicus' treatise, *De Proprietatibus Rerum*. Bulimia has been reported in conjunction with a range of other symptoms, including vomiting, syncope, and a perverted craving for non-foods and offensive substances known as *dog-hunger* or *canine appetite* (Parry-Jones, B. 1991). It remains in current usage as 'bulimia' and, more specifically, as 'bulimia nervosa' (Russell, 1979). References occur in medical texts from the thirteenth century onwards, including the earliest known illustration of a bulimic in *De Arte Phisicali et Cirurgia* by John of Arderne, published posthumously in 1412 (Parry-Jones, & Parry-Jones,

1995). From the earliest period, bulimia appears to have been viewed as a digestive disorder or to be due to a structural abnormality of the stomach or oesophagus, causing premature emesis. From the medieval period onwards, it was observed that despite excessive intake, body weight could be normal or even underweight. Although discussions of the bulimic condition featured relatively frequently in medical texts and lexicons, published case descriptions were rare. About 50 have been identified by the authors, relating, in descending order of frequency, to Britain, France, Germany, Switzerland, Poland, America, and Italy, from the seventeenth to the twentieth century. These included cases of *congenital bulimia* or *acoria*, where sensations of satiety appeared to be absent; ravenous eating accompanying worm infestation; grotesque forms of morbid appetite verging on monstrosity, and, more contentiously, abnormally increased intake in states of nervous prostration during convalescence from acute illness or fevers. Additionally, during the nineteenth century, there were reports of short-term bulimia in the context of head injury or brain disease (Shearman, 1856; Putawski, 1890; Paget, 1897).

Britain

A handful of bulimic cases were reported in the seventeenth and eighteenth century (Mortimer, 1745) and with greater frequency during the nineteenth (Porter, 1829). There were, however, only occasional references in eighteenth-century medical texts (Rowley, 1788) and the long entry on *boulimos* and *caninus appetitus* in James' *Medicinal Dictionary* (1743) was exceptional. The most practical contribution was by Cullen (1780), whose nosology categorised bulimia according to its most prominent symptoms. His tripartite presentation of gorging, syncopal, and emetic forms remained operative into the nineteenth century and was influential outside Britain. Hooper (1820) elaborated upon Cullen's classification, breaking down bulimia into nine sub-categories, according to the concomitant physical manifestations, which were then targeted for treatment. From the late eighteenth century onwards, entries on bulimia, usually repeating the same sensational cases, appeared in many encyclopaedias. Copland's *Dictionary of Practical Medicine* (1858) provided a comprehensive description, including cases and references to European literature. He viewed bulimia as an aberration in quantity, just as pica was an aberration in quality, of the ingested substances and recommended that treatment should address 'the habit of eating largely, voraciously, and without due mastication'. Combe (1847) referred to patients with prodigiously increased appetite, inordinate food craving, and imperfect digestion, and Druitt (1862) characterised bulimia as 'an intense, sickening sense of emptiness, with ravenous desire for food'; essentially abnormal, not the intensification of a healthy appetite, but 'a disordered sensation, a subjective hunger'. Bradshaw (1864) referred to many extraordinary dyspeptic cases where 'hunger assumes the character of madness . . . the impulses . . . are under no kind of moral control,' emesis occurring soon after ingestion, with rapid return of food craving. Salter (1868), described a girl aged 17 with 'hysterical vomiting', whose weight loss, food-stealing, and post-prandial emesis is suggestive of bulimia. By the late nineteenth century, acceptance of a psychological component in bulimia and recognition of its predominant manifestation in neurotic subjects, especially hysterical women,

was emerging (Allbutt, 1897; Riddle, 1914). Occasional cases conforming with some of the later diagnostic criteria of bulimia nervosa were reported, chiefly in German sources, during the 1930s (Habermas, 1992b). Endorsement of the fact that bulimia attracted little British attention is provided by its complete absence from the *Medical Annual*, 1883-1983, and merely passing references to it, under anorexia nervosa, in Henderson & Gillespie (1927-1962). Nevertheless, by the 1960s, with its extreme concerns about body weight and shape, bingeing, self-induced vomiting, and to a lesser extent purging had developed insidiously within some presentations of anorexia nervosa. Increased awareness of such patterns of bulimic behaviour during the 1970s led to the definition of bulimia nervosa (Russell, 1979). Interest in this previously little-known disorder escalated subsequently, notably through the work of Fairburn in Oxford.

Europe

Interest in bulimia is discernible in French sources from the seventeenth century onwards (Riverius, 1668). Sauvages (1768) outlined seven sub-types of bulimia, in which the voracity was accompanied by emesis, worms, absence of evacuations, diarrhoea, atrophy, convulsions, and stomach over-acidity. Sensational French cases were re-reported in British medical journals (Galignani & Galignani, 1864), and there were substantial entries in French encyclopaedias and medical dictionaries (Blachez, 1869). Of particular relevance was a contribution by Guipon (1864) on bulimic and syncopal dyspepsiae. Although Blancard in Holland had drawn attention (1702) to a 'defection of spirits' which often accompanied bulimia, Guipon appears to have been among the earliest to develop this theme, referring to the frequently depressed mood of bulimic patients, their night-eating, and benefits from remedies acting on the nervous system. Bulimic symptoms were described in four patients by Janet (1908), while Déjerine & Gauckler (1915) referred to a condition of 'psychic hunger', much rarer than 'mental anorexia', occurring in neurasthenic patients obsessed by a continual need to eat. References to bulimic subjects displaying closer affinities to patients with bulimia nervosa occurred in early twentieth-century German literature. The classic case of 'Ellen West' c. 1914 (Ellenberger, 1970) incorporated anorectic and bulimic episodes, with fear of fat, bingeing, fasting, and laxative abuse, terminating in suicide. Abraham (1927) referred to sudden hunger attacks and night-bingeing among neurotic female patients, who were obliged to carry food with them at all times to assuage paroxysmal hunger, and in 1932, Wulff (cited in Stunkard, 1990) described four cases of compulsive eating, depression, and loathing of corporeality in neurotic women, which afford striking similarities with bulimia nervosa patients. A Swiss paper on bulimia (Peyer, 1888) subdivided it into acute and chronic forms, the former being 'extremely rare'; onset was preceded by neurasthenic or hysterical symptoms and the extraordinary craving took the pattern of daily hunger attacks or continuous, insatiable hunger. Peyer interpreted bulimia as a neurosis, advising that treatment should target the primary morbid state. Three reports entitled 'Bulimia' published in British medical journals, concerning one Italian and two Polish subjects, demonstrate the wide clinical variations encompassed by this term in the nineteenth century, describing respectively hyperphagia in the form of gluttony (Anonymous, 1865),

nervous symptoms and insatiable hunger leading to obesity (Lubelski, 1875), and temporary bulimia following a fractured skull (Putawski, 1890).

USA

Two interesting nineteenth-century American cases were reported. A Boston practitioner (Crane, 1822) attended a 26 year-old woman who indulged her huge appetite privately and vomited after every meal, providing a perfect example of Cullen's *bulimia emetica*. The second account concerned a 14 year-old boy who complained of endless hunger, ate continuously, and doubled his weight. Hemmeter (1898) viewed 'hyperorexia' as either an idiopathic neurosis or as a symptom of organic disease, occurring particularly in women aged 20-40 years. Without rapid gratification of their violent hunger, patients showed 'signs of fright, weakness, headache, pallor, palpitation of the heart, roaring noises in the ears, and gastric distress'. In 1905, Paton referred to bulimia, in the form of food-bolting, among manic-depressive patients, and Crohn (1925) differentiated between excessive consumption at any one time (gluttony) and bulimia, 'the constantly recurring and imperious desire of food at short intervals . . . and even throughout the night'. He believed bulimia was not a disease, but was symptomatic of a psychoneurosis or hysteria, with associated gastric mechanisms. Even more important were Crohn's observations that bulimia could occur in, or alternate with anorexia and that one of his patients slept in her corset after bingeing, in order to hold her stomach 'tight', the latter providing an early intimation of body shape concern. In contrast, the psychoanalytic approach of Leonard (1944) interpreted bulimia, or functional vomiting, in a 28 year-old woman as 'somatic expressions of a personality disorder precipitated in early childhood by emotional conflicts' incorporating food.

Rumination disorder (merycism)

The term *rumination*, referring to both man and animals, derives from the Latin *ruminor*, to bring up from the throat or to chew the cud, while *merycism*, referable only to human behaviour, comes from the Greek *merukismos*, implying abnormal regurgitation of ingestae. Although classical writers were familiar with animal rumination through Aristotles' description of the stomach of ruminants, the process was not identified in man until the seventeenth century, but mental rumination, as seen in obsessive-compulsive disorder, featured in Latin texts from classical times and in English sources from the late sixteenth century (Parry-Jones, B., 1994). This relatively rare disturbance of gastric and oesophageal function was first described by the Italian anatomist Fabricius ab Aquapendente (1618). In rumination, a bolus of food is regurgitated, without nausea, into the mouth, shortly after eating, and subjected to second mastication like cattle chewing the cud. The remasticated mass is generally re-swallowed, but sometimes ejected, resulting in nutritional deficits. The process generally afforded comfort and pleasure to the ruminator, and food was claimed to taste pleasanter than on initial consumption. Rumination was regarded as a degenerate behaviour, having an atavistic analogy to cud-chewing in herbivores.

Aquapendente's two published cases emphasised bovine characteristics, such as the small horny excrescences reported on the foreheads of the father and the brother of the first two patients, although the anticipated multiple stomachs failed to be substantiated at post-mortem. Mounting curiosity culminated in the publication of *Merycologia* (Peyer, 1685), which gave detailed accounts of human and bovine rumination, citing 12 cases (11 males, 1 female). Case descriptions remained rare, however, only 18 being published between 1618 and 1750 (Kanner, 1936). Data presented in this chapter are based on approximately 100 cases and upon information concerning homogeneous groups of ruminators, particularly infants and the mentally retarded (Parry-Jones, B., 1994).

A literature review covering the seventeenth to the twentieth century (Parry-Jones, B., 1994) demonstrated intermittent interest in this curious phenomenon throughout Europe, and in the late nineteenth century, in the USA also. Although the first case, a Paduan nobleman, was described in Italy (Aquapendente, 1618), the greatest single contribution to the early history of the disorder came from Switzerland, with the publication of Peyer's definitive tract on merycology, comprising 11 cases, (Italian, Swiss, English, and German) (Peyer, 1685). These early cases fostered bizarre aetiological fantasies, such as the transmission of bovine attributes via the semen (Aquapendente, 1618); the 'maternal impressions' theory, based on close maternal observation during pregnancy of ruminating animals, which affected the foetus in utero, and environmentally-induced rumination, from human co-habitation with cattle (Peyer, 1685). Theories of hereditary transmission and degenerative stigma proliferated. Some of these myths were suppressed in the eighteenth century, after Morgagni's dismissal of the idea of compound stomachs and Pipelet's refutation of the alleged connection between rumination and the growth of horns by human subjects (Bourneville & Séglas, 1883). Few additional cases were published before the nineteenth century, but rumination was the topic of 15 European inaugural medical dissertations between 1662 and 1859. During the nineteenth century, references to rumination disorder occurred in medical texts and there were sporadic accounts of ruminators of all nationalities utilising their digestive facility commercially as exhibitionists.

Britain

Pre-nineteenth century contributions on rumination disorder were sparse. Brockbank (1907) claimed that its earliest reporting by an British author was by Burnet (1673), whose Appendix featured Aquapendente's first case and that of a ruminating German medical student. However, Peyer's published cases (1685) included a 50 year-old London man, whose rumination was recorded in 1667. More information was available for the second British ruminator, reported, as an outstanding rarity, by Slare (1691). This 20 year-old Bristol man, whose father also 'chewed his cud to a lesser extent', indicated that re-masticated food tasted better than on first ingestion and that his rumination ceased (like that of cattle) during sickness. The persisting stigma concerning the bovine nature of rumination was exemplified in a moralistic re-discussion of the Bristol case by Goldsmith (1864), which claimed that eating was 'a pleasure of so low a kind, that none but such as are nearly allied to the quadruped,

desire its prolongation'. The eighteenth century was almost devoid of British references to rumination, other than descriptions of experimentation on a regurgitating Hussar, reported in an Edinburgh dissertation (Stevens, 1777); Erasmus Darwin's account of the sequential rumination of white and red gooseberries by an exhibitionist satisfying the whims of his spectators (Winslow, 1880), and retrospective diagnosis of Dr Johnson as a merycole (Parry-Jones, B., 1992).

The increasing frequency of British accounts of rumination during the nineteenth century suggests heightened awareness and interest in the condition. Another Edinburgh dissertation (Vos, 1830) discussed a healthy ruminating male adolescent, whose father, uncle, and paternal grandfather also ruminated. Copland published 13 pages on rumination in the *London Medical and Physical Journal* (Copland 1821) and a comprehensive section in his *Dictionary of Practical Medicine* (Copland, 1858). Rumination, principally case reports, featured occasionally in *The Lancet* and the *British Medical Journal* and its occurrence in malingering (Nelson, 1876) and in mental retardation (Read, 1845) were topics of discussion. The *Medical Annual* contained three references to rumination between 1888 and 1931, incorporating German and American cases and advice on using thickened, high caloric feeds for ruminating infants. The condition began to be referred to in general medical textbooks; Allbutt (1897), for example, classified rumination with bulimia under 'neuroses of the stomach'. The most important early twentieth-century publication, on a ruminating tin-plate worker (Brockbank, 1907), confirmed rumination in five generations of one family, among whom the activity was perceived as a 'normal' process. Twentieth-century literature was concerned particularly with rumination in mentally defective subjects or in infants; infant rumination was noted during the first decade, and was focused on initially by paediatricians concerned about failure to thrive (eg. Paterson, 1930). If organic pathology was not demonstrable by gastro-enterologists, psychological causes (inadequate stimulation, poor maternal relationship, and neurotic traits) were attributed, and rumination fell increasingly within the scope of psychologists and psychiatrists. Cameron (1925) acquired international acclaim for his classic account of the secretive act of infantile rumination. In infants and the mentally retarded, the condition was acknowledged to be serious, sometimes fatal, when nutrition became impaired, but its description as an innocuous 'habit', which was not necessarily harmful to the health of normal adults, nevertheless, persisted. It is noteworthy, however, that rumination disorder did not feature in any edition of Henderson & Gillespie (1927-1962). An editorial (1971) in the *British Medical Journal* refocused on the history of rumination, discussing Brockbank's unique contribution (1907) and the necessity to exclude physical abnormalities in investigating infantile rumination. Having pursued a similar historical theme, a *Lancet* editorial (1987) made the important observation that rumination occurred in 'intellectually intact adults', as well as in infants and the mentally retarded, and suggested that the general incidence of the disorder was higher than generally perceived. During the last quarter century, debate has been resumed whether rumination is a disorder, a learned habit, or a benign condition (Levine *et al*, 1983). In the USA, Blinder (1986; Blinder *et al*, 1988a) has strongly contested viewing rumination as benign, emphasising that it could incorporate various medical complications and impose serious social constraints

on sufferers, and could lead on to bulimia nervosa (Fairburn & Cooper, 1984) or anorexia nervosa (Thomä, 1967; Larocca, 1988).

Europe and USA

During the nineteenth century, there were occasional case reports in the French medical literature (Tarbés, 1813; Gallois, 1889) and an important study by Bourneville & Séglas (1883) on rumination among the mentally retarded at the Bicêtre. German contributions were more substantial, encompassing published cases (Alt, 1888; Singer, 1896) and several dissertations. Especially important was a thesis by Heiling (1823), which noted the frequency of childhood onset. It is indicative of their growing interest in infant rumination that most pre-1917 case reports occurred in German sources. In the USA, an early reporting of habitual regurgitation in a 24 year-old male 'simulating rumination in lower animals' (Graham, 1874) was succeeded by a flurry of interest during the 1890s, including a paper on merycism read to the American Neurological Association (Hammond, 1894), case-orientated discussions about hereditary and degenerative facets (Runge, 1895; Talbot, 1898), and its interpretation as a gastric neurosis allied to nervous vomiting (Sinkler, 1898). Early twentieth-century American literature revealed similar preoccupations with the psychological and psychosocial implications of infant rumination (eg. Grulee, 1917), and Kanner (1936) provided a much-needed scholarly history of this neglected disorder.

Pica (malacia)

Pica and its older form *cissa* originated from the Latin *pica*, a magpie, a miscellaneous feeder. Referred to by Hippocrates (460-361 B.C.) and, in the context of pregnancy, by Aegineta in the seventh century, it has demonstrated remarkable consistency as a medical term. (Parry-Jones, B. 1991) Abnormal appetite for coal, earth, and salt was described in the mid-thirteenth century by Bartholomaeus Anglicus, but he did not actually employ the term *pica*. Its earliest English language usage was in 1563 (Gale), in relation to children and pregnant women eating coal. Historically, pica was heavily female orientated, occurring most flagrantly in pregnancy and chlorosis. The bizarre ingestae characteristic of chlorosis received copious comment in medical and literary sources from the sixteenth century onwards, providing confirmation of extensive European distribution of this enigmatic disorder. Pica, occurring occasionally in males, was classed as an irrational, depraved appetite, with specific terms for some manifestations, such as *geophagia* for earth-eating and *pagophagia* for abnormal ice consumption (Parry-Jones, B., 1992). The former, nevertheless, represented a cultural norm in some primitive societies, and was not conceived as a medical problem unless it visibly undermined the constitution. Ninety cases of pica have been located in printed sources, supported by voluminous general discussions, particularly in relation to well-defined, pica-prone populations – pregnant women, chlorotic girls, young children, and the mentally retarded (Parry-Jones & Parry-Jones, 1992).

Britain

Pre-nineteenth-century sources contain frequent references to pica, including interpretive theories, case-histories, and suggested treatments. The potency of the craving was already recognised in the sixteenth century. Fenner (1587), for example, volunteered a harmless cure; '... when one is oppressed with the disease Pica, so that hee can not eat anie thing but pitche, or what he lusteth after, he should be cured by eating no meate at all; but by turning his lust into the rage of famine'. Seventeenth and eighteenth-century sources focus almost exclusively on pregnant and chlorotic pica. Both Plot (1686) and Harris (1742) reiterated sixteenth-century concerns about ill-effects, including birthmarks, which could affect the foetus if maternal cravings were thwarted. Harris also made the interesting claim that pregnant pica was class-related, occurring in 'hysterick Women . . . fine, delicate Ladies, who spend the whole Prime of Life in Dress and Idleness,' and only rarely in working women on plain diet. Most authors agreed that it was generally accompanied by distaste for normal food. Some of the bizarre likings of young girls included pepper (Moffett, 1655), mortar (Peirce, 1697), chalk, plaster and coal (Woodward, 1757) as well as leather, rags, cork, and nut-shells (Dover, 1742). Extensive portrayal in seventeenth- and eighteenth-century literary sources of pica in the context of 'green-sickness' (chlorosis), including classic descriptions by Flecknoe (1658) and in *The Spectator* of 1712 (Bond, 1965), affords evidence of prolonged familiarity with this form of eating perversion. Theories of causation were relatively rare, but Dover (1742) implicated the effects of abdominal and thoracic compression through corseting young females to achieve a fashionable 'shape', while Whytt (1767) suggested that specific substances were selected to remedy stomach disorders.

Nineteenth-century British literature occasionally referred to *cachexia Africana* or dirt-eating (Mason, 1833), but most commonly discussed chlorotic and childhood pica. Graham (1840) noted psychological accompaniments - lowered mood and incapability of sustained interest. Johnson (1849) described voracity alternating with deficient appetite in chlorotic adolescents, as well as 'that strange symptom, . . . pica', in which indigestible and revolting articles, such as sealing wax, lucifer matches, smelling salts and stearine candles, became objects of delight. He claimed the blood was 'poor and watery', like 'the thin juice of a cherry,' and that fatal phthisis could follow. Acknowledgement of the prevalence of pica is provided by its comprehensive inclusion in medical dictionaries (Copland, 1858; Mayne, 1860; Hoblyn, 1892). The former introduced the term 'pseudorexia', stating that it occurred frequently in idiots 'from want of ability to discriminate,' but also in pubertal females without either hysteria or chlorosis. Generally, Copland maintained, it was symptomatic, but it could present as a primary disorder, 'owing to a habit, commenced at first with a view of improving the shape and complexion', involving the consumption of chalk and vinegar by young females. This confirms that adolescent dietary control centring on intake of non-nutritive substances had attracted the attention of physicians at a period preceding the description of anorexia nervosa.

Crisp (1862) highlighted a medical complication of pica - perforated ulcer of the stomach - relating its incidence in chlorotic girls to their consumption of coal, cinders, and foreign bodies. Depraved appetite, according to Foot (1867)

was not confined to childhood, but was seen in adult males and in females with deranged menstruation. The disorder could be hereditary, occurred in the well-fed and the poor, and could alternate with anorexia. Children with pica treated by Foot displayed 'emaciation, with impeded development, anaemia, constipation, sometimes diarrhoea, great dullness of spirits . . . colicky pains.' Published cases included three two-year-olds discussed by Corrigan (1859), a geophagic girl infested with roundworms (Dukes, 1884), and 11 children treated by Thomson (1895). The latter rejected popular theories interpreting pica either as a compensatory appetite or as a local neurosis of the stomach, viewing it as 'a sort of minor psychosis', to be classed with bad habits such as thumb-sucking and masturbation. Allbutt (1898) expressed concern about the penchant of chlorotic girls for slate pencils and vinegar and their avoidance of meat. Thomson (1895) and, in the USA, Kellogg (1897) were among the earliest to draw attention to pica in the mentally retarded and the insane. The former noted its occurrence, particularly coal-eating, in 15% of children at the Scottish National Institution for Imbeciles, and the latter identified appetite perversions, including coprophagy, among asylum inmates, particularly those suffering from chronic schizophrenia.

There has been renewed interest, during the 1980s, in pica in the mentally handicapped. Kinnell (1985), discussing its incidence in autism and Down's syndrome, recalled that both Kraepelin and Krafft-Ebbing had considered pica a sign of severe psychopathology and a 'vegetative sign of psychosis'. His study revealed pica in 70% of autistic subjects, as against 4% in Down's syndrome patients, possibly reflecting the greater psychotic tendencies in autism. McLoughlin (1987) discussed pica in chronic schizophrenia, psychosis, personality disorder, and mental handicap, and (1988) as a cause of death in three mentally handicapped men. Increased likelihood of fatalities from indiscriminate intake of non-foods, dangerous objects, and contaminated, raw, or frozen items makes pica a serious problem among disturbed or mentally retarded populations. Similar deviant eating behaviour was reported by O'Brien & Whitehouse (1990) among mentally-handicapped adults in community placements.

A three year-old girl with pica for mud, plaster, and coal, accompanied by food aversion, was referred to by Gee (1907) and two British paediatricians, Cautley (1910) and Still (1924), who cited 14 cases, concurred that the morbid 'habit' of childhood pica had multiple causes, including neuroticism, mental defect, digestive disturbance, worms, inherited tendencies, boredom, and poor general health implicating anaemia. Deficient food consumption, however, rather than perverted appetite, remained the commonest reason for referral. Invited replies to a BBC radio programme on pregnant pica (Harries & Hughes, 1958) yielded information on 991 cravings for both foods and non-foods; the compulsion was described as strong, and sometimes, as in bulimia and in rumination, indulged in secretly, with a sense of shame. Although two 1960s textbooks (Mayer-Gross, *et al*, 1960; Sim, 1968) included entries on child and pregnant pica, Henderson & Gillespie (1927-1962) made no reference to either. With the exception of a *Lancet* leader (1959), supporting strong causal association between iron deficiency and pica, there were few other references during the 1960s and 1970s, except for a child case study (Shrand, 1961), and discussion of nutmeg pica in an adult woman (Rees, 1964). The only two references in the *Medical Annual*, 1883-1983, comprised a report on visceral larva migrans due to toxocara infestation from eating dog-contaminated soil, (Shrand, 1965),

and an account (Sharman, 1973) of pica, anaemia, and lead-poisoning among immigrant children in substandard accommodation in Britain. Pica in socially deprived or severely subnormal children was the subject of a book-length study by Bicknell (1975). Subsequently, the most important contributions have been those by McLoughlin (1987) and McLoughlin & Hassanyeh (1990), the latter of which provides a rare account of pica in confirmed anorexia nervosa.

Europe

References to pica can be traced throughout European medical literature of the sixteenth to the nineteenth century. Nine inaugural medical dissertations on pica were published between 1562 and 1719, suggesting that there was sustained academic interest in 'depraved' or 'erroneous' appetite. In France, Champier (1508) noted irrational appetite for coal, chalk, and other oddities during pregnancy and in men and women with 'corrupt' stomachs; Liébault (1582) likewise discussed pregnant cravings, and described two teenage chlorotic girls subsisting on plaster, brick dust, nutmegs, and spices, while Riverius (1668) defined pica as desire for 'evil, unprofitable and hurtful things', occurring occasionally in males, but most frequently in pregnant, chlorotic, or amenorrhoeic females, who consumed acidic or earthy substances, spurning normal foods. During the nineteenth century, there were continuing French reports of chlorotic pica. Trousseau (1872), recognising the risks of chronicity, advised compliance with the 'insensate cravings', while Lasègue (1884), having named the most preferred non-edible substances as coal, plaster, and small stones, quoted the case of a girl whose absurd craving led her to consume half the frock-coat of her drawing master. Lange, the German physician credited with the earliest published account of chlorosis, under its original name of 'virgin's disease', referred (1589) to the 'amazing' pica of pregnancy, believed to be due to retention of impure blood during menstrual suppression. Alberti (1727) appears to have been among the first to refer to pica in infants. Soltmann (1894) defined pica on a psychological dimension as a 'nutritional neurosis' caused by 'cortical excitation of the taste areas under the influence of severely depressive emotional states, such as anxiety, worry, sorrow, deprivation or homesickness'. Pica is traceable also in early Dutch sources. Forestus (1606) described the 15 year-old daughter of a Delft corn merchant; blanched and retarded in growth, she consumed quantities of corn seeds, and chalk. Blancard (1701) attempted to differentiate between pica and malacia, giving the former general applicability and restricting the latter to pregnancy, while Boerhaave associated depraved appetite specifically with young girls, who became pale, weak, and undernourished through consuming 'sand, lime, wool and other such trash' (Van Swieten, 1744).

USA

In contrast, the earliest reports of pica in America occur only in the nineteenth century, referring to geophagia, with its accompanying anaemia due to hook-worm infestation and malnutrition, among negro slaves on southern American plantations (Mason, 1833) or to chlorotic pica. Chlorosis had become common

in the USA by the end of the nineteenth century, and Harland (1882) was not alone in referring to an alarming proneness of young girls to 'vitiated cravings and finical likings' for chalk, magnesia, slate pencils, and acidic pickles, their rejection of wholesome food and the romanticising of female invalidism. A valuable transcultural perspective on the many forms of perverted eating was provided by Gould & Pyle (1898), stressing that an intake which was abnormal in some cultures could be entirely acceptable in others. Early twentieth-century American references to pica, defined by Holt & McIntosh (1933) as a neurosis of the alimentary tract, reveal predominantly paediatric concerns, namely the risks of childhood lead encephalopathy and the frequent manifestation of pica in mentally retarded children, often in the context of social deprivation and inadequate maternal stimulation (Kanner, 1955). Such issues were explored in a monograph by Cooper (1957), which also provided a comprehensive historical account. From the 1960s onwards, a sequence of papers on abnormal ice consumption (pagophagia) and its relationship with iron-deficiency anaemia (Reynolds *et al*, 1968; Coltman, 1969; Brown & Dymont, 1972) and individual case reports on pica for both foods and non-foods were published in American medical journals (Parry-Jones, B., 1992). Other important American contributions included assessment of iron deficiency as a causal factor in pica (Gutelius, 1969), consideration of the life-threatening complications of geophagia (Gelfand, 1975), a comprehensive review of diagnosis and treatment (Blinder *et al*, 1988b), together with research on eating behaviour implicating early childhood pica as a prospective risk factor for the later development of bulimia nervosa, (Marchi & Cohen, 1990).

Comment

This review of British contributions to the eating disorders illustrates not only the different levels of attention paid to each individually, but also fluctuations of interest in each disorder over time and the changing involvement of physicians, psychiatrists, paediatricians, endocrinologists, and gastro-enterologists in diagnosis and treatment. Brief excursions have been made into parallel developments in Europe and the USA, to provide a wider context against which British contributions could be measured, in order to highlight national differences in description and interpretation, and in the pace and form of medical involvement in the eating disorders. Occasionally, it has been possible to indicate interaction, if not co-operation, between British practitioners and colleagues in other countries, particularly in France and the USA, such as that between Gull and Lasègue, and between Playfair and Weir Mitchell. During the latter part of the nineteenth century, English synopses of important items in foreign literature and translations of French articles featured regularly in British medical journals and aspiring British practitioners were, therefore, in no way isolated, through lack of linguistic skills, from European influences.

Food abstinence has always been an arresting condition, and the long-term medical engagement with food refusal, both pre- and post- Gull, is wholly predictable. It follows that by far the greatest volume of published literature on eating pathology by British practitioners in the nineteenth and early twentieth centuries has focused on anorexia. The initial influence of Gull and Lasègue

slowly raised the level of awareness of anorexia nervosa as an identifiable entity among physicians and alienists, and it is not surprising that most of the important early contributions on the disorder were published in British and French journals. During the protracted period of confusion of anorexia nervosa with Simmonds' disease, British practitioners remained largely unconvinced by the pervasive endocrinological attributions. Sheldon (1939) made the revealing observation that although the English literature on anorexia nervosa presented 'quite a tranquil surface', there was 'a very considerable ferment of opinion going on in American and Continental literature'. This ferment was resolved, ultimately, by British research (Sheehan, 1948). Although primacy has now been conceded, by a narrow margin, to Lasègue rather than Gull as the first to described the disorder, substantial acknowledgement has to be made, nevertheless, of the overall influence of the British contribution in the clinical delineation of anorexia nervosa.

In contrast, British interest in bulimia, as in most other European countries during the period before its elevation to syndromal status as 'an ominous variant of anorexia nervosa' by Russell (1979), was confined to the publication of sensational cases of hyperphagia and intermittent discussion of aetiology and treatment. It was not regarded as an eating disorder in its own right until the late 1970s, and even then, its inter-relationship with, and differentiation from, anorexia nervosa remained controversial. The course of its early historical evolution was essentially as a symptom in many, chiefly physical disorders and its identification with psychological factors, particularly depression, neuroticism, and hysteria, became confirmed only in the nineteenth century. A mild but sustained interest in bulimia, reflected in British sources from the medieval period on and including the publication of a number of descriptive case reports, became transformed into a major involvement in the syndrome of bulimia nervosa by British psychiatrists from the late 1980s.

The period of flamboyant description of rumination by Aquapendente and Peyer was followed by a century and a half during which the disorder had a relatively low profile throughout Europe, related to some extent to its partial acceptance as a curious habit or a benign condition, rather than a medical problem. Although two British ruminators were recorded in the seventeenth century, there was little evidence of British interest in the disorder before the mid-nineteenth century and only sporadic references, mainly to unusual cases, occurred in European literature. As greater clinical attention was given to the condition during the early twentieth century, particularly by paediatricians and psychologists, British, German and American sources all reflected the prevailing interest in the psychological and psychosocial implications of infant rumination in relation to failure to thrive, and focused also on rumination in mental retardation and on the influence of hereditary factors in the transmission of the disorder. Recent awareness of the concept of psychiatric co-morbidity has resulted in attention being drawn increasingly to the occurrence of rumination as a collateral feature in both anorexia nervosa and bulimia nervosa.

Whereas British interest in rumination has shown a tendency to increase over the historical period considered, something of a reverse process has occurred with regard to pica. The condition attracted widespread comment in British – and indeed in European sources – from the sixteenth to the late-nineteenth century. Thereafter, its reporting has decreased dramatically. This can be explained,

fairly positively, in terms of the disappearance of chlorosis in the second decade of the twentieth century, by advances in the specialty of haematology and by steady improvements in child care, which have provided mothers and carers with deeper insight into the fundamental psychological, nutritional, and nurturing needs of young children. More recently, there has been a resurgence of interest in pica in mental retardation and autism, with greater awareness of its life-endangering potential in this context. In the twentieth century, therefore, pica, which is probably still seriously under-reported, has become a focus of interest chiefly for paediatricians, child psychiatrists, and specialists in mental handicap.

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3 'Stamping out addiction': the work of the Rolleston Committee 1924-1926

VIRGINIA BERRIDGE

The report of the Departmental Committee on Morphine & Heroin Addiction attracted almost no public attention on its publication in 1926. A document which legitimated a crucial alliance between doctors and the state in the management of addiction was virtually ignored. *The Times*, which briefly summarised the report, judged it not worthy of editorial comment.¹ The medical and pharmaceutical journals naturally found it of interest.² But the popular papers, ever eager to publicise dope trafficking, the cocaine menace, and the dangers posed by 'drug fiends', gave it no space at all. Yet the report's conclusions did much to shift the focus of British drug policy. A penal and prohibitive policy based on police control and government direction was subsumed into a more liberal form, where the medical profession played a significant role. The Home Office rather than the Ministry of Health remained in overall charge of policy, but doctors reclaimed the drug addict as their own. Partnership between that department and the profession replaced confrontation.

How had this situation come about? Opium, which had been freely available until the middle of the nineteenth century, had moved to a more restricted situation by its end. In the first half of the century, the distinction between medical and non-medical use was difficult to make, and the drug was in widespread use for a variety of common ailments. The habit forming properties of opiates were recognised, but not dealt with specifically within a medical framework. The concept of 'treatment' for 'addiction' was absent, and those doctors who came into contact with regular opiate users did not automatically, or often, consider that treatment was appropriate. Opiate use was not defined as a problem requiring medical intervention. Much began to change towards the end of the nineteenth century. The rise of medical specialisms brought with it a newly defined interest in the concept which was termed 'inebriety', encompassing both alcohol and drug use on a habitual basis. Doctors began to organise themselves round the study and management of the concept, in Britain through the Society for the Study of Inebriety, founded in 1884.³

Before the First World War, management of addiction had to some degree been professionalised. Two strands marked pre-war control: management of supply through the pharmaceutical profession, and management of the user by means of the inebriates and lunacy legislation. Pharmaceutical control dated back to the mid-nineteenth century. Both the 1868 Pharmacy Act and the 1908

Poisons & Pharmacy Act reserved the sale of narcotics to the self-regulating monopoly of professionally qualified men. After 1908, opium, morphine, and cocaine were transferred to Part One of the Poisons Schedule. Sale was intended to be to 'known' purchasers only, with the requirement of a signature in the pharmacy's poisons book – a requirement which seems often to have been laxly enforced.⁴

Other moves towards control encompassed the user as well as the use of narcotics. Addicts were occasionally admitted to lunatic asylums under the provisions of the Lunacy Acts, but their numbers appear to have been small. Sir Ronald Armstrong-Jones, superintendent of the Claybury Asylum and recognised as an authority on addiction, quoted 40 such cases admitted over an unspecified period, in an address given to the Society for the Study of Inebriety in 1915. Bethlem Royal Hospital admitted only eight narcotic addicts between 1853 and 1892.⁵ There were also moves to bring narcotic users under the aegis of the Inebriates Acts, which provided both compulsory and voluntary treatment for those convicted of offences concerning drink. The Inebriates Committee of the British Medical Association, chaired by Dr. Norman Kerr, President of the Society for the Study of Inebriety, pressed for the widening of the Acts of 1888 and 1898 to include all forms of drug addiction. But inebriates legislation remained limited so far as addiction was concerned. The definition of 'inebriate' ensured that only those consuming liquid forms of the drug could be admitted for treatment; morphine injectors were outside the competence of the Acts.

Hoped-for powers of compulsory detention of non-criminal inebriates (which would have included drug addicts too) remained unenacted. The BMA urged this course of action on the 1893 Departmental Committee on the Treatment of Inebriates; it was accepted by the 1908 Departmental Committee on the Inebriates' Acts, but the translation into practice never occurred. A series of abortive bills, introduced between 1912 and 1914, included a new definition of 'inebriate' which encompassed all forms of narcotic use. But these never became law and the old Inebriates Act itself fell into disuse. Other avenues of legal control were also limited. The BMA's proposal before the Royal Commission on the Care & Control of the Feeble Minded in 1908 – that both 'habitual inebriety' and 'drug habits' should be a matter for the Lunacy commissioners – was recognised in the 1913 Mental Deficiency Act only to the extent that 'mentally defective' habitual drunkards could be compulsorily admitted.⁶ Although the management of both supply and the user was recognised to be a professional medical and pharmaceutical matter, systems were undeveloped prior to the war. Much treatment appears to have taken place in private nursing homes.⁷ Nor was medical expertise over addiction firmly located within one particular area of medical specialty. The Society for the Study of Addiction, founded in 1884, formed the main specialist vehicle for the elaboration of disease views of addiction. But its members were a heterogeneous group, with Medical Officers of Health, temperance surgeons, general practitioners, asylum superintendents, and owners of nursing homes among its supporters, together with a wide variety of lay members, often with temperance connections.⁸ Addiction was certainly not a specialist mental health matter, nor was its management located in any state-run system of treatment. However, a disease view of addiction (or inebriety), which had developed largely since the late nineteenth century, seemed to place the condition implicitly within the medical and psychiatric mould.

The series of events which threatened to disrupt these emergent patterns of medical control have been discussed elsewhere and can be briefly summarised here.⁹ Crucial factors were; the emergence, under American pressure, of a system of international control, given world-wide applicability through the post-war settlement at the Treaty of Versailles; and a war-time 'emergency' based on the leakage of narcotics through smuggling and the supposed use of cocaine by soldiers in the West End of London. Regulation 40B under the Defence of the Realm Act, issued in July 1916, covered cocaine as well as raw and powdered opium, and included for the first time requirements that drugs were to be available on a prescription-only basis. The requirements of international control led to the extension of this regulation into the post-war 1920 Dangerous Drugs Act; this was at a time of intense media pressure and concern, in particular around the Billie Carleton case of 1918-19¹⁰ The issue of regulations under the Act in the early 1920s and struggles round the Dangerous Drugs Amendment Act of 1923 made it clear that both doctors and pharmacists were to be subordinated to an approach which had as its primary aim the 'stamping out of addiction'. Professional freedoms to dispense and to prescribe were to take second place to a prohibitionist approach.

The conflict between different approaches was epitomised by the comments made by Mr. D'Eyncourt, a Marlborough Street magistrate, in May 1922. D'Eyncourt had before him Jean Nisbet, a cook housekeeper, charged with obtaining money and a steamship ticket by deception. She was a morphine addict who had become dependent on the drug after nursing a sick husband and herself surviving two major operations. A nursing home place was available for her. She seemed the model of a 'medical addict', rather than the 'dope fiend' of popular imagination. But the magistrate thought otherwise. Imposing a nine-month sentence, he commented, "These people have only to say that they are taking drugs or something of that sort to be nursed and attended to. It seems to me that if they bring themselves into a state in which they are indifferent to the rights of property, and a great many other things . . . They must be punished".¹¹

These views were echoed at a higher level. The Home Office, rather than the Ministry of Health, had assumed departmental responsibility for drug policy in the post-war period, building on *ad hoc* arrangements during the war, and ultimately on the administration of the Inebriates Acts, which had been located in the Home Office. The influence of Malcolm Delevingne, an Under Secretary who had been involved in the pre-war administration of these acts, was considerable. Delevingne was an accomplished bureaucrat, a natural designer of regulations, who was determined that drug control would remain in his office's control, and that the 'stamping out of addiction' was only a short-term activity.

Delevingne was much influenced by the model of American drug policy, where the 1914 Harrison Act was being applied in the post-war period in such a way that doctors, pharmacists, and the addicts they supplied were being criminalised.¹² But the British situation differed significantly from the American in more than one way. Most importantly, the role of medicine in relation to addiction was more developed in Britain. Doctors of all types laid claim to the addict as a proper case for treatment, supported by an ideology which saw addiction as a disease with both physical and psychical components. As a *Lancet* commentary put it in 1922,

As the law now stands, confirmed drug maniacs can scarcely hope to avoid coming in contact with it, while if its purview is extended . . . then a still larger group of cases, the legitimate concern of the practitioner, will have forced on them a legal aspect to which no doctor can remain indifferent . . . Are cases of nervous disease, for that is what drug cases are in essence, to be sent to prison for their 'cure'? The profession is surely not so impotent, or indifferent, as to countenance further spread of this particular practice.¹³

The struggle for control of the addict came to a head over two particular issues; doctor addicts and maintenance cases, where doctors prescribed narcotics to those who could not otherwise function without them. The doctor addict was a fundamental loophole in any structure of control, yet closing the loophole involved a challenge to professional autonomy. Maintenance prescribing impinged on the sometimes uncertain barriers between 'medical' and 'non-medical' use. The Home Office wished to dispense with both loopholes in the law. But in order to do so, it needed medical support and legitimation for the non-medical line. This was the paradox at the heart of the Rolleston Committee's appointment and deliberations. It was the Home Office's own approach to the Ministry of Health at the end of 1922, its request for a medical opinion, its continued advocacy of the need for a committee throughout 1923, against Ministry prevarication, which marked the beginnings of a more liberal policy. It was with varied motives – part tactical move to secure acceptance of an absolutist line from an independent and recalcitrant profession, and to a lesser extent, some uncertainty about the correct line to take – that the Home Office first approached the medical profession. The matter arose in quite a small way, initially through the need to obtain medical advice on the treatment of addiction and in particular, the method of gradual reduction of dosage. A Home Office letter to the Ministry of Health in November 1922 sought advice on a number of drug cases where doctors had claimed that they were prescribing drugs in attempts to break the habit by gradually reducing the dose. This, to the Home Office, was just an excuse. "Though this defence in many cases is only a pretext, it is very difficult in such cases to secure the conviction of the practitioner on a charge that he is obtaining or assisting the patient to obtain the drugs for purposes other than legitimate medical practice." Seeking an investigation into this method of treatment, the Home Office cited New York experience as a precedent, and suggested the appointment of a committee of the Royal College of Physicians to undertake the investigation.¹⁴

The Ministry, perhaps fearful of more Home Office initiatives, was more concerned to establish a body of case law on the subject. Continued Home Office pressure led to the drawing up of a memorandum on the treatment of addiction by Dr.E.W.Adams, a Ministry medical officer who later became the secretary of the Rolleston Committee and the main drafter of its report. Adams laid out the full range of the medical approach. Addiction was a disease involving treatment, and therefore a doctor's proper concern. It was right for the diseased person to be treated in a humane way, by gradually diminishing doses. But the doctor could not become a simple purveyor of drugs. To obtain them, the addict must accept professional definitions, declare himself 'sick', and be willing to undergo treatment. He wrote,

the duties of the physician are concerned with the treatment, cure and relief of disease and his actions must be governed by these considerations. He is not a purveyor of drugs for all and sundry . . . If the addict is unwilling to enter into the relationship of patient to physician, but admits that he is merely coming to obtain supplies of a drug which he cannot otherwise get, then it is the clear duty of the doctor to refuse the case. But if the habitu   desires treatment as a sick person for the relief of his pathological condition, the physician must be allowed to use his discretion.¹⁵

Doctors treating addiction were professionals, not tradesmen; and the Ministry view was based on a striking insistence on the rights and needs of doctors prescribing for addicts, rather than on consideration of addicts' needs.

The Home Office view, expressed over the months before the Rolleston Committee was finally appointed in September 1924, was still that the medical profession could be used to legitimate a prohibitionist stance. But increasingly, the complexities of the situation became apparent. One particular case, an addict called Henderson, who had himself called at the Home Office to press his case in 1922, seemed to have made an impact. Thomas Henderson, the son of a well known Edwardian portrait painter, and addicted to morphine for nearly 40 years, begged,

I claim to be a useful life to the state, teaching others to earn their living and only asking to be permitted to earn my own, and I appeal to you . . . to see with unbiased eyes, and I implore you . . . not to crush me out under this new law . . . Morphia has not corrupted me . . . it has never tempted me to do wrong in any respect . . . I only ask to be left in the hands of my doctor.¹⁶

By November 1923, Delevingne, who had been in discussion with Dr. George McCleary and Dr. James Smith Whitaker at the Ministry, was asking, 'how would you deal with the case (which you told me at our last interview you considered a possible one, though you were not sure that everyone would agree with you) of the addict whose mental and physical powers cannot function properly without a periodical dose of morphine?'¹⁷ The committee's appointment, under the chairmanship of Sir Humphrey Rolleston, President of the Royal College of Physicians, was in order to wrestle with these problems of medical competence.

Delevingne may still have hankered after an absolutist approach – he noted that the committee was to enquire in to the 'circumstances in which and the conditions under which, morphine should be supplied, if at all, to addicts', but the constitution and membership of the Rolleston committee underlined that the decisions would be based on medical premises and criteria. The committee's terms of reference entitled it to,

consider and advise as to the circumstances, if any, in which the supply of morphine and heroin (including preparations containing morphine and heroin) to persons suffering from addiction to those drugs, may be regarded as medically advisable and as to the precautions which it is desirable that medical practitioners administering or prescribing morphine or heroin should adopt for the avoidance of abuse, and to suggest any administrative measures that seem expedient for securing observance of such precautions.

No official Home Office representative sat on the committee, although one member, Sir William Willcox, was medical adviser to the Home Office. The nine members were all medical – four practising medical men and five salaried government doctors, mostly from within the Ministry of Health. The secretaries of the committee, R.H.Crooke and Dr.E.W.Adams, also came from within the Ministry, and Adams had drawn up the earlier memorandum on treatment and maintenance which had done much to shape the Ministry's opinion. Notions of treatment and attitudes towards the addict's condition were still in a state of flux, and the membership of the committee symbolised the debates which had taken place over previous years. The 'Ministry men' on the committee took more of a back seat; Dr. Smith Whitaker, Dr. Fulton, Divisional Medical Officer, and Dr Cullon of the Scottish Board of Health were less tangible presences than some of the key professional figures. Dr. Bone, representing the BMA, was a figure of political importance. But Rolleston himself, Professor W. E. Dixon, Sir William Willcox, and to a lesser extent Dr. Branthwaite of the Board of Control, were the leaders in the formation of policy. Dr John Fawcett, consulting physician at Guy's, also sat on the committee, but appears not to have made any significant independent contribution to its conclusions.

It was Dixon and Willcox who had contributed most to the public discussion of addiction. It would be an over-simplification to portray the discussions of the Rolleston committee as a gladiatorial combat between the opposing conceptions of the two men; nevertheless, it is clear that their views largely defined the terms of the debate and represented distinct tendencies in British medical thinking on addiction. Willcox was a practising physician with a large consulting practice, as well as an honorary appointment at St. Mary's. Forensic science was his specialty. He had a long-standing connection with the Home Office, and played a major role as crown expert witness in murder trials (among them the Crippen and Seddon cases). Willcox's connections with the police and involvement with government officials and a non-medical government department were unusual for a medical man of the period. He had been arguing for greater controls on drugs since 1915, and in the 1920s, his had become an influential voice in the formulation of Home Office policy. Views on disease for him were less firmly rooted than for others in the profession. In his Norman Kerr lecture on drug addiction in 1923, he expressed the opinion that the habit began as a vice and only later became a medical condition. He was at pains to point out, too, that although in many cases there was an undoubted medical cause for addiction, (in which he included toxæmia from bad teeth and septic tonsils), there were also 'vicious causes' – the use of drugs simply for their stimulant properties, the contamination of addicts by others, and the association with 'unnatural sexual vice.' Compulsory institutional treatment and abrupt withdrawal of narcotics were his favoured treatment modes.¹⁸

The contrast with Professor W. E. Dixon, the exponent of what can be termed the 'liberal/professional' view on the committee, was not only a policy difference, but a personal one, too. Dixon was one of the world's leading pharmacologists, the first Reader in Pharmacology at Cambridge. 'Life and research were alike an adventure to him', later commented the *Journal of Pharmacology*, 'he attacked them both with a buoyant and courageous heart and an open mind.'¹⁹ Dixon's initial reputation had been made, not in the criminal courts, but in the 1890s phase of experimentation with drugs, which had both medical and social

dimensions. Dixon, like Havelock Ellis, had been a student at St. Thomas's, and both men published articles on their experimentation with mescal within a year of each other. Ellis' piece, in the *Contemporary Review* in 1898, attracted much attention; Dixon's in the *Journal of Physiology* the following year, was less noticed. His article on cannabis indica in the *BMJ* in 1899 concluded that the drug's abuse was rare and "grossly exaggerated".²⁰ He remained a lively defender of cannabis into the 1920s, when debates about the relationship between cannabis and insanity were again current.²¹ He also became, in the 1920s, a leading public exponent of medical opposition to criminalisation of the addict and a strong opponent of the American approach to drug control. Both in the press and before his medical colleagues, he defended a liberal stance, drawing parallels with the earlier history of insanity. In a paper given to the Society for the Study of Inebriety in 1924, he said,

The Americans are now discussing whether drug addiction is a medical issue or a police problem, and the special police Commissioner in charge of the Narcotics Division of the New York police . . . concludes that, 'because of the fact that addiction has as its origin or is coupled with crime or with criminal environment in 98 per cent of the police cases, the problem is in the category of criminology, and therefore comes within the province of the police.' To me this is suggestive of the medieval; lunatics were in those days treated on these lines; they were punished, subjected to every indignity, but without effecting cures or diminishing the number of lunatics.²²

Fundamental to Dixon's view was a belief in the disease view of addiction and the neurotic nature of the addict.

Rolleston, the chairman of the committee, appears to have inclined more towards Dixon's stance than to that of Willcox. Rarely if ever obtrusive in its discussions, he was nevertheless a firm and conciliatory chairman, known for his tact and skill in securing agreement.²³ Named after his great uncle, Sir Humphrey Davy, Rolleston's view had been formed through his association with Sir Clifford Allbutt, as joint editor of the encyclopaedic *System of Medicine* (1905-11). Allbutt had been one of the earliest medical advocates of hypodermic morphine, and also one of the first to warn about the dangers of its abuse. Clearly, Rolleston's orientation supported the 'medical' view of addiction. In 1924, commenting on a paper from Dixon dealing with cocaine addiction, he argued that 'treatment should be directed not on the lines of making the victim a subject of police action, but by controlling the environment so as to cut off the supply of the drug.'²⁴

Several of the committee's members thus held strong views on addiction and of current trends in policy, but the results of the committee's deliberations were no foregone conclusion. Their 23 meetings, from 15 October, 1924 to 24 October, 1925, were not simply a facade. Doctors had not been called on so directly before to formulate policy in this area. In the various pre-war discussions, their views had been presented from the sidelines, as evidence,²⁵ whereas in 1924-6, the Rolleston Committee saw doctors admitted to a central role in deciding policy.²⁶ Views of various aspects of control – addiction and its treatment, notification, the medical tribunal, the control of chlorodyne – were all in a state of flux or undecided at a fairly late stage of drafting. But underneath the discussion lay a

resolve that, whatever form of control was decided on, should remain largely a matter for doctors, with the state as a secondary partner.

The range of evidence presented to the committee emphasised that this was a medical matter. Of the 34 witnesses, 24 were doctors (including the prison doctors, whose outlook was rather different). Nine of these were consultants; Dr. Cox, Mr. Turner, and Mr. Le Fleming represented the British Medical Association; Dr. Hogg was superintendent of a leading nursing home dealing with addicts, Dalrymple House at Rickmansworth; four were prison doctors; and seven were practising GPs. A written report was presented by Dr. Dill Russell, a Regional Medical Officer; and a questionnaire was circulated to GPs dealing with the treatment of addiction. The pharmaceutical interest was also represented, although the eight representatives of the profession and the drug industry who gave evidence, were not summoned until the committee's thirteenth meeting on 20 March, 1925, when certain major points of the report had already been settled.²⁷ The other major body of evidence came from the penal point of view – a weighty Home Office memorandum, oral evidence from Sir Malcolm Delevingne, and from Sir Archibald Bodkin, Director of Public Prosecutions. No addicts were called to give evidence, although there was plenty about them in the evidence presented. Membership and witnesses both emphasised that control was to be a matter for doctors and bureaucrats alone.

Within the medical ranks, however, opinion was divided. Some held to the traditional view of professional self-regulation; while others saw the interests of the state and the wider community as paramount. Dr. Webster, a GP witness, was from the latter camp. His view was that, 'there were larger issues at stake than personal pique or professional privilege. In cases of addiction the moral damage was liable to extend beyond the addict himself by way of example and precept. The public safety was probably the first consideration.'²⁸ There was no consultant versus GP antithesis, for the consultants were not united in seeing the response to addiction in a liberal light, and GPs also voiced many opinions. Dr D. K. Henderson of Glasgow Mental Hospital and Sir James Stewart, both specialists in the subject, favoured abrupt withdrawal; Sir Maurice Craig from Guy's and Dr. Hogg were both resolutely against it. Opinions were varied on most points of administration and policy, but medical witnesses spoke as members of the same profession, with the desire to retain control of an area already categorised as medical.

Since the committee had its origins in Home Office policy, it was that Office whose thinking largely structured the way it began its work. A memorandum from Sir Malcolm Delevingne was placed before the members at its first meeting, together with an appendix detailing 25 representative cases of addiction which had come to its attention, and an additional appendix, submitted to support the 'abrupt withdrawal' line of treatment, which cited addict cases who had been sent to prison. Delevingne himself attended the second meeting of the committee on 31 October, 1924. His next contact was some months later, on 8 June, 1925 when, at the seventeenth meeting, there was further consideration of the draft report. He was in regular contact thereafter with the committee, which also took evidence from Sir Archibald Bodkin, the Director of Public Prosecutions, who attended twice, as well as submitting written evidence.

The views expressed in the Home Office memorandum and in Delevingne's own evidence indicated how far the official view had been modified since the

initial approach to the Ministry of Health at the end of 1922. There was no outright condemnation of gradual withdrawal, or of maintenance prescribing, although the Home Office, in its emphasis on abrupt withdrawal in the prison cases, and in its circulation of American and Canadian material on drug addiction which recommended abrupt withdrawal and prosecution of doctors supplying drugs to addicts, showed clearly where its ultimate sympathies lay. But the reality of addiction and its incidence, in particular the Henderson case, had also forced a change in the Home Office attitude.

Even Willcox, who had interviewed Henderson in March, 1924, had been forced to conclude that here was a case which needed indefinite maintenance.²⁹ Evidence provided of cases showed that fair numbers of addicts were, for one reason or another, going to prison; those who did not had all been committed to some form of institutional treatment under a degree of legal duress. But the Home Office was proceeding very much from one case to the next on the maintenance issue. The wife of a Harley Street physician, being supplied twice a month by a doctor in Hastings with 144 grains of morphine, had passed Home Office scrutiny, largely because her doctor adopted a recalcitrant attitude and 'held out no hope of any material alteration'. Yet in the case of a Glasgow tram conductor prescribed for by a doctor in Glasgow, pressure from the Home Office and the implicit disapproval of the GMC had forced the discontinuance of supplies.³⁰ Without a clearly defined policy on maintenance, it would be the articulate patients and the obdurate doctors who had the best deal. The lack of established procedures also favoured doctors whose prescribing was extremely liberal. The case of Dr. Connor in London had concerned the Home Office since 1919. He admitted prescribing cocaine purely for the gratification of addiction, and had given a written undertaking to prescribe only for cases he could treat. But he had later returned to his practice of prescribing freely.³¹ Medical addicts were a problem for the Home Office, and the memorandum floated the idea that a black list of addicted doctors should be circulated to wholesale dealers, with a view to putting them on their guard.³² In his evidence, Delevingne favoured abrupt treatment, and suggested that it should be made an offence for an addict not to disclose to his doctor the names of other doctors from whom he was, or had been receiving drugs.³³

The committee had asked Delevingne to provide evidence of the size and nature of the 'drug problem'. But the Home Office evaded the issue, and merely presented 25 'representative cases'. What did emerge from the memorandum and from other evidence presented to the committee was that the problem was a small one, and that many cases had medical connections, or if not, came from broadly middle-class backgrounds. The number of working-class addicts may well have been under-represented in evidence, given that opiate-based patent medicines, chlorodyne in particular, were still subject to much less control. Nevertheless, the Rolleston cases represent some sort of cross-section of addiction in Britain in the 1920s. Take for example, Dr. Hogg's evidence, given at the committee's third meeting on 1st November. Of 195 addicts admitted to the Dalrymple Home over the previous 25 years, (out of 1,300 male inebriates), 100 had been taking morphine and opium, 16 morphine and cocaine, 8 heroin, and 26 cocaine. Of 150 cases, he had analysed, 58 had some medical connection. Medical men mostly used the hypodermic method, chemists took the drugs by mouth, and dentists used cocaine.³⁴ Other specialists reported

similarly. Sir Maurice Craig, physician at Guy's, had seen some three dozen cases over an unspecified time. 'Finding it difficult to reconcile statements in the press with my experience in my own practice, that I only come across these cases in extraordinary small numbers, I have for some years asked medical practitioners whom I have met in consultation whether they see many of these patients, and the answer is always 'none' or "very few".'³⁵ Of the general practitioners, only Dr. Webster from Newcastle-under-Lyme had seen more than a few over 22 years; he had attended a dozen cases, and had known of 60-70 altogether. But he was known to have a special interest in the subject, and fellow practitioners would refer other cases to him.³⁶ The only exception to this pattern was in the evidence of the prison medical officers, which suggested levels of working-class chlorodyne use which rarely came to the attention of a general practitioner.³⁷

The committee's final report in fact accepted that numbers were small and probably declining. Addiction was not a threat, and there was no need to disrupt the medical nature of the issue. In its final form, the report gave official sanction to the disease view of addiction. Witnesses to the committee distinguished between the immediate and deep-seated causes of addiction. The most important immediate cause, as several witnesses admitted, was careless medical prescribing. But there was also a belief in the underlying 'neurotic' causation of addiction, particularly the 'abnormal personality'. Sir Maurice Craig, for example, 'had never seen a perfectly normal person become a subject of drug addiction'. Although 'certain degenerate types are undoubtedly susceptible', addiction was equally likely to befall the 'highly hyper-sensitive and intelligent person'. Witnesses emphasised that addiction was allied to insanity, 'a variety of toxic insanity' in Purves-Stewart's words.³⁸ The published report echoed these conclusions, 'the condition,' it concluded, 'must be regarded as a manifestation of disease and not as a mere form of vicious indulgence. In other words, the drug is taken in such cases not for the purpose of obtaining positive pleasure, but in order to relieve a morbid and overpowering craving.' 'Nervous instability' was an important predisposing factor, with 'injudicious use' also leading to addiction, but cases arising from 'vicious indulgence and curiosity' were felt to be unusual.

The committee's view of disease clearly underlined the advent of psychological and Freudian-influenced perspectives. But how was the addict to be controlled? Here the issue of maintenance prescribing was the most important aspect. Were all cases to be treated with 'cure' as the end, or was there a separate class of addicts who required continuous prescribing in order to function normally? The committee devoted much time to this issue – although in one sense, it had been decided before the first meeting. The pre-Rolleston exchanges, and in particular the Henderson case, had done much to legitimate this type of addict. In the committee, the Home Office presentation of American and Canadian evidence, which put the opposite point of view, made little headway. One member (possibly Dixon) suggested to Sir Maurice Craig that 'the Harrison Narcotic Law in America, which dictates to medical men how they should use narcotics, had merely had the effect of alienating the profession in that country, and any restrictions . . . would have the same effect here.'³⁹ Medical evidence to the committee on this issue was by no means unanimous, but those who supported maintenance were direct and unequivocal. Medical control was the essential element. Without maintenance, there was the danger, as Craig put it, that addicts

'would leave the doctor and go elsewhere'. The committee clearly made up its mind early on this point. An interim memorandum, produced around the time of the twelfth meeting, already accepted maintenance as inevitable. There was,

in the community a class of persons from whom the drug cannot completely be withheld. Among these are persons who, if regularly supplied with a small dose, can live an otherwise normal life, but become incapable of so carrying on their duties if that dose cannot be obtained . . . there are persons to whom, unless they can be induced or compelled to undergo institutional treatment, the continued administration of morphine over prolonged periods and possibly for life, is necessary for the relief of morbid conditions intimately associated with the addiction.⁴⁰

Doctors kept their control over addicts, but there was also discussion over how far control mechanisms should be extended. The issue of notification of addicts to an outside authority was a thorny one, both in the 1920s and later. The matter had been raised at the first meeting by Dr. Fawcett, who envisaged notification to a central government department - either the Home Office or the Ministry of Health. This idea had not been in the Home Office memorandum, and when questioned on the issue, Delevingne suggested notification to a Regional Medical Officer. The doctors who gave evidence inclined in both directions, either supportive or adamantly opposed to the idea. The first draft of the committee's report, discussed at its seventeenth meeting on 8 June, 1925, certainly took a pro-notification line. The committee was divided, and significantly, it turned to the BMA, the guardian of doctors' rights, for advice. The BMA appointed its own committee to consider this and other points; it came down strongly against notification. Dr. Bone, the BMA representative on the Rolleston committee, argued from the professional perspective that, 'The confidential relationship between doctor and patient would be disturbed . . . The notification of cases of addiction in medical men themselves would be particularly obnoxious'.⁴¹ This was the stance which found its way into the final report.

The danger of driving the patient away from the doctor was a continuous theme in much of the evidence presented to the committee. For this reason also, they decided on gradual methods of treatment, where cure was a possibility. Branthwaite from the Board of Control was the main advocate of the alternative of compulsory treatment. In a memorandum produced at the committee's eighteenth meeting, on 26 June, he argued for compulsion as a means of maintaining and even extending medical control. Recognising that the profession was already losing addicts to police control and to prison, he proposed a form of legal guardianship: semi-compulsory medical control within the framework of lunacy legislation was to replace penal control. This procedure he saw as a means of 'medicalising' the 'non medical' addict who was currently going to prison, as well as retaining control over the respectable 'medical' addict.⁴² But these suggestions did not find a place in the final report. The committee was less concerned with the 'vicious' addict in prison than with those who already accepted the medical definitions of their condition. Its conclusion was that 'the gradual method is to be preferred . . . abrupt or rapid withdrawal should not be carried out except in a well-appointed institution and with the aid of skilled nursing and constant

medical supervision. It is therefore unavailable for the treatment of those who cannot or will not enter institutions'.⁴³

This was a humane conclusion, of benefit to addicts, but the emphasis was also on the doctor's needs. Doctors' liberties and the free exercise of professional rights were often the points at issue. The medical tribunal to deal with errant doctors was a particular example. This appears to have been one of the last contentious areas discussed by the committee. It arose out of suggestions made by Delevingne and Bodkin as a means of securing control which was likely to be more effective than the uncertain results of court action. The original idea was to limit its operation only to medical addicts. At the BMA's suggestion, the tribunal's competence was extended to cover those who were overprescribing for others, as well as for themselves. The tribunal, said Dr. Bone to the BMA's own committee, 'avoids very undesirable publicity and the still more undesirable penalties of fine, imprisonment or removal from the Medical Register. It provides for trial by sympathetic judges who may be assumed to have a thorough understanding of the offences alleged'.⁴⁴ The tribunal was an instrument of professional self-regulation as well as of state policy.

The desire for professional autonomy also informed the committee's rejection of the proposed compulsory requirement for the addict to reveal his previous doctors' names. Official regulation was seen as further intrusion into the doctor-patient relationship. Such a scheme was rejected, leaving, in Delevingne's eyes, 'a very serious loophole in our system of control'.

The question of the doctor addict had informed the provision of a medical tribunal, which was one of the thorniest problems with which the Home Office had to deal. Many of the cases appended to its memorandum concerned medical addicts, and a further case presented during the committee's hearings also underlined the difficulties of control. Dr. AGCF had admitted to Dr. Llewellyn, a Regional Medical Officer, that he was a morphine addict, taking ten grains a day for the past five years. Unwilling to submit to medical supervision, he pointed out that he had tried to rid himself of the habit, but that after two or three days' abstinence, he became physically unable to do his work and was obliged to fall back on the drug to keep going. The RMO reported that the doctor's principal considered that Dr. AGCF was doing his job well and was liked by the patients.⁴⁵ Delevingne's response was severe. The Home Office, he wrote, 'would only be prepared to take a lenient view of the case if you will give . . . a written undertaking to place yourself entirely in the hands of a responsible medical practitioner for the treatment of your drug addiction'. In discussion in the committee, however, the idea of 'self treatment' by doctor addicts was not ruled out; and the final report tended to leave the whole question open. It was nowhere specifically stated that a doctor-addict would be automatically deprived of the right to possess or prescribe dangerous drugs. The medical tribunal was thought sufficient to deter abuse; certainly the black list of doctor addicts which Delevingne suggested was unacceptable. The proposed scheme encountered pharmaceutical opposition as well; Wippell Gadd of the Drug Club, the wholesalers organisation, pointed to the possibility of libel actions by doctors who had been wrongly listed.⁴⁶

The committee avoided a prohibitionist response also where the banning of heroin was concerned; this matter was a live one on the international scene at the time. The United States had proposed to the second Geneva Opium

conference at the end of 1924 that heroin, already banned in the US, should be under world-wide prohibition. Medical opinion in Europe was opposed, and the Health Committee of the League of Nations had decided against prohibition at a meeting in September 1924. For this reason, the proposal, perhaps surprisingly emanating from W.E. Dixon, was a non-starter before the committee. Ministry of Health approaches to the GMC, the Royal College of Physicians, and the BMA, had already evoked little enthusiasm. The committee's report took the view that heroin addiction was more disastrous in its effects and more difficult to cure, but 'in this country addiction to morphine in any of its forms is much the more common'. What the Geneva conference did decide to do was to bring all heroin preparations within the scope of control. In Britain, the Dangerous Drugs Act was extended to cover these as well as Indian hemp and coca leaves. Delevingne attended the Rolleston Committee to explain that the decisions had been taken on international, rather than on medical grounds.⁴⁷ International control legislation carried greater weight than the embryo alliance between doctors and the state.

Morphine and heroin were the main drugs considered by the committee. Cocaine was pervasive in the case histories reviewed, and many of the cases were those where that drug had been used in conjunction with an opiate. But the liberal framework of maintenance prescribing was not considered; the special reputation the drug had acquired since 1916 would have prevented that. However, events did force the committee to consider one aspect of drug taking which normally fell outside medical competence. The Chief Medical Officer, Sir George Newman, forwarded a letter he had received in January 1925 from a GP in Hampstead. This doctor had been called in to treat the family's nurse, found in a state of collapse and suffering, as was later realised, from chlorodyne withdrawal symptoms.

The house was searched for empty chlorodyne bottles. The net result was that sufficient bottles were found to fill seven pillow cases and a *large* open wicker basket to the top. Unfortunately two pillow cases have been emptied away into the dustbin, but the remainder I have locked up in a room.⁴⁸

As a result, the committee's terms of reference were extended to advise if preparations which contained morphine and heroin, but which currently fell outside the provisions of the Dangerous Drugs Act, should be brought within the Act. Chlorodyne had figured little before the committee, although the prison cases had included some where this substance had been abused. The preparation had been a matter of concern to the medical and pharmaceutical professions in the 1890s, when both a rising yearly total of deaths and professional moves for further control had led to attempts to restrict its availability. A series of law cases had then brought chlorodyne within the terms of the Pharmacy Act, but subsequently, other drugs had pushed chlorodyne out of the news. The investigations conducted by the BMA into 'secret remedies' and the pre-war Select Committee on patent medicines had implied that further restriction was at hand but the Dangerous Drugs Act had left 'household remedies' of this type unrestricted. Pharmaceutical control was maintained without medical intervention. Mr. Pilkington Sargeant, President of the Pharmaceutical Society, favoured the standardisation of chlorodyne, so that it fell within the Dangerous

Drugs Act. But his Society would 'oppose the extension of the Dangerous Drug Act regulations to preparations not at present coming within their scope, for as the regulations stand every addition constitutes a fresh injustice to the pharmacist.'⁴⁹ The pharmacists wanted this course of action, while the BMA favoured the reduction of morphine content to make the preparation innocuous. The medical voice prevailed.

By the time of the committee's last meeting on 24 October 1925, no major area of disagreement remained. It had completed its work in a year and nine days, although the report was not actually signed until 21 January 1926. All the major features of the committee's discussions were present. Laying stress on the small dimensions of the problem and defining addiction as a disease, it condemned abrupt withdrawal, legitimised maintenance doses, and established the medical tribunal to deal with these cases and with medical addicts. Notification, the black list of doctors, and the compulsory declaration by addicts about previous medical treatment were all dropped. Chlorodyne was the only preparation newly brought within the provisions of the Act. In the Home Office, Delevingne was delighted. The report was, he wrote, 'admirable and important . . . The part of the report which deals with the medical treatment of addiction and the precautions to be observed by the medical profession in connection with the administration or supply of morphine to addicts is, I believe, the first full authoritative pronouncement on the subject, and should be of great value as a guide to the private practitioner in dealing with a very difficult class of case.'⁵⁰ From the start, the Rolleston Report was a potent force in defining policy.

Symbolically also, the report has assumed considerable importance. It has been widely credited with establishing something called the 'British system' of drug control, which, so it is argued, prevented Britain from experiencing the worst excesses of an American style 'war on drugs', with consequent criminalisation of both addicts and the doctors who prescribed to them. In the 1960s, Rolleston was a beacon for liberal reformers of the American drug control system.⁵¹ In the 1980s and 90s, it has retained its symbolic importance for those who wish to legitimate maintenance treatment and for advocates of harm-minimisation among them. The policy significance of Rolleston is clear, but what was its real significance? There seems little doubt that it was the result, rather than the cause of the low numbers of British addicts and of a general *laissez faire* medicalised approach over the next 40 years. It was, as David Downes has commented, 'a system of masterly inactivity in the face of a non-existent problem'.⁵² When the numbers of addicts increased in the 1960s and the type of addict changed, then the Rolleston response was modified. But the deliberations of the committee, described in detail for the first time in this paper, also lead to a number of other conclusions.

The Rolleston Committee and its activities symbolised a much closer relationship than before between doctors and the state in the area of drug addiction. Doctors moved from the sidelines, advising on policy, into a central position in its creation. Although the Home Office retained ultimate control, the mediating role of the newly established Ministry of Health and the role of its medical civil servants, was an important one. Rolleston was not a medical 'victory', for the proceedings of the committee show a process of accommodation between the Home Office and the profession – a balance of interests which could change as the pattern of addiction itself altered. Nor, as the detailed discussions show,

was medicine the automatic guarantor of a non-punitive approach. Compulsory treatment and abrupt withdrawal could be parts of the medical response. The ultimate driving force was the preservation of the doctor's own position of power and control; driving addicts away from doctors had to be avoided.

Drug addiction, as the evidence to the committee demonstrates, was not an exclusively psychiatric preserve in the 1920s. It was still an area of medical heterogeneity, with physicians, asylum doctors, and general practitioners all taking an interest. Yet the conceptualisation of addiction and of the addict's fundamental neurosis underlines psychiatry's move away from the institutional option, the influence of Freudian and psychological perspectives, and the search for a middle-class clientele – one which 1920s medical addicts admirably provided.⁵³ It was not until the 1960s when the 1965 Brain Report established a specialist clinic model, that psychiatry moved centrally and officially into the management of addiction. In the 1980s, that psychiatric hegemony was again challenged.⁵⁴ But the alliance between doctors and the state over drug addiction, established by Rolleston, still remains as a fundamental basis of policy.

Notes

- 1 *Times* 20 February, 1926.
- 2 'Morphine and Heroin addiction' *Lancet*, 1 (1926), 448-9; 'Morphine and Heroin Addiction: departmental Committee's report', *British Medical Journal*, 1 (1926), 391-3.
- 3 Berridge and G. Edwards, *Opium and the People: Opiate Use in nineteenth century England* (London, Yale University Press, 1987).
- 4 For details of the operation of the early Pharmacy Acts, see Berridge and Edwards, *Opium and the People*, also V. Berridge, 'Opium and Oral History', *Oral History*, 7 (2), (1979), 48-58.
- 5 Armstrong-Jones, 'Drug addiction in relation to mental disorder', *British Journal of Inebriety* 12, (1914-15), 125-48; the Bethlem admission registers were scanned from 1853 onward for cases of drug addiction.
- 6 42 and 43 Vict.ch.19. Habitual Drunkards Act, 1879; 51 and 52 Vict.1888.ch19. An Act to amend the habitual drunkards act, 1879; 61 and 62 Vict.ch.60. An act to provide for the treatment of habitual inebriates; Parliamentary papers (P.P.) 1893-94. XVII. 597. *Report from the Departmental Committee on the Treatment of Inebriates*, P.P. 1908, XII. 817; *Departmental Committee on the Inebriates' Acts*, P.P. 1908. XXXV. *Royal Commission on the Care and Control of the Feeble Minded*. Volume 1. Minutes of evidence. P.P. 1912-13. II. 843. A Bill to consolidate and amend the law relating to inebriates.
- 7 See, for example, the evidence to the Rolleston Committee of Dr. Hogg, medical superintendent of Dalrymple House, a nursing home at Rickmansworth, which specialised in such cases. Ministry of Health papers. MH 58/276. Minutes of third meeting.
- 8 For a history of the Society and its activities, see V. Berridge, 'The Society for the Study of Addiction, 1884-1988' *British Journal of Addiction special issue*, 85 (8), (1990).
- 9 Fuller analysis of the preceding moves towards control is in V. Berridge 'War conditions and narcotics control: the passing of defence of the Realm Act Regulation 40B', *Journal of Social Policy*, 7 (1978), 285-304; and V. Berridge, 'Drugs and Social policy: the establishment of drug control in Britain 1900-1930' *British Journal of Addiction*, 79 (1984) 17-29.
- 10 For details of the Carleton case see V. Berridge, 'The Origins of the English Drug 'Scene', 1890-1930' *Medical History*, 32 (1988), 51-64; and M. Kohn, *Dope Girls. The Birth of the British Drug Underground* (London, Lawrence and Wishart, 1992).
- 11 *Daily Express*, 19 May, 1922.
- 12 For the history of U.S. drug policy, see D. Courtwright, *Dark Paradise: Opiate Use in America Before 1940* (Harvard University Press, Cambridge, 1982); D. Musto, *The American Disease, Origins of Narcotic Control*. (New York: Oxford University Press, 1987; originally published, New Haven: Yale University Press, 1973).
- 13 'Drug Addiction and its treatment', *Lancet*, ii (1922), 137.

- 14 Home office papers.Substitutes for cocaine.Home office letter to Ministry of Health 2 November,1922.H.O.45/19427/434228.
- 15 Memorandum by Dr.E.W.Adams on the treatment of drug addiction 17 February, 1923. Ministry of Health papers MH58/275.
- 16 Home office papers, cases under the Dangerous Drugs Act, 1922-23. H.O.45/432886/17a. The Henderson case 21 November, 1922.
- 17 Home office papers H.O. 45/451408/10a. Correspondence between McCleary,Smith Whitaker and Delevingne,March-November,1923.
- 18 Sir W. Willcox, 'Drug Addiction' *British Journal of Inebriety*, **21** (1923-24), 75-97; see also obituaries of Willcox in the *Lancet*, **ii**, (1941), 88; and *British Medical Journal*, **ii** (1941), 180.
- 19 'W.E. Dixon' (obituary and bibliography) *Journal of Pharmacology*, **xliv** (1932), 3-21.
- 20 W.E.Dixon, 'The pharmacology of cannabis indica' *British Medical Journal* **2** (1899), 1354-7.
- 21 Letter from W.E. Dixon, *British Medical Journal*, **ii** (1923), 1179-80.
- 22 W.E.Dixon, 'Cocaine addiction' *British Journal of Inebriety*, **22** (1924-25), 103-12.
- 23 *Times* 25 September,1944. Obituary of Sir Humphrey Rolleston.
- 24 See discussion following Dixon's paper,W.E.Dixon, 'Cocaine addiction',*British Journal of Inebriety*, **22** (1924-25),103-112.
- 25 For a comparative discussion of the changing relationship between doctors and the state, see V. Berridge 'Doctors, drugs and AIDS: patterns of power compared' (forthcoming).
- 26 The papers of the Rolleston Committee,which are drawn upon in the following discussion are in Ministry of Health papers. MH 58/275,276,277 and 278.1923-1926.Medical committee on drug addiction.
- 27 The committee decided at its twelfth meeting to ask the Pharmaceutical Society to nominate two witnesses, as well as the Drug Club. At its thirteenth meeting, it took evidence from representatives of the Pharmaceutical Society and of the Retail Pharmacists' Union. Ministry of Health papers. MH 58/276. Minutes of thirteenth meeting, 20 March, 1925.
- 28 Evidence of Dr. W.Webster,Ministry of Health papers MH 58/278,Evidence presented to the Rolleston Committee.
- 29 Home office memorandum to the Rolleston Committee.Appendix 1.25 cases of addiction known to the Home office.Comments on the Henderson case (number 18) by Willcox.Ministry of Health papers. MH 58/277.
- 30 Appendix 1.25 cases of addiction known to the Home office. Ministry of Health papers. MH 58/277 Evidence presented to the Rolleston committee.
- 31 Dr.Connor's case was number 1 in the Home office appendix.
- 32 Home office memorandum,Ministry of Health papers. MH 58/277.
- 33 Evidence by Malcolm Delevingne, second meeting of Rolleston Committee, 31 October, 1924. MH 58/276.
- 34 Evidence of Dr.Hogg,third meeting of committee,1 November,1924.Ministry of Health papers MH 58/276and 277.
- 35 Memorandum and evidence from Sir Maurice Craig,Ministry of Health papers, MH 58/277.
- 36 Evidence from Dr.W.Webster,Ministry of Health papers, MH 58/278.
- 37 Appendix 2 to Home office memorandum;summary of cases treated in prison.Ministry of Health papers,MH 58/277.
- 38 Evidence of Sir James Purves-Stewart,Ministry of Health papers, MH 58/277.
- 39 Further evidence from Sir Maurice Craig,recorded comment.Ministry of Health papers,MH 58/277.
- 40 Note on present position as regards evidence already taken and questions on which further evidence seems desirable.Papers of Rolleston Committee.MH 58/278.
- 41 British Medical Association. Documents placed before the committee on drug addiction,1924-25. See also the Committee's memorandum to the BMA and the BMA's evidence on points arising out of the memorandum 11 July 1925.Ministry of Health papers.MH 58/278.
- 42 Minutes of Rolleston Committee, 18th meeting, 26 June, 1925.MH 58/276.
- 43 *Report of the Departmental Committee on Morphine and Heroin Addiction*. (London, 1926).
- 44 BMA committee on drug addiction 1924-25.
- 45 Case of Dr.A.G.C.F. in papers of Rolleston committee. MH 58/278.
- 46 Letter from H.Wippell Cadd to R.H.Crooke,10 March,1925.Papers of Rolleston committee,MH 58/278.
- 47 A strong protest had been made on this point by Dr.Bone of the BMA,who felt that the Home office should have brought the matter before the Rolleston committee.Minutes of Rolleston committee.MH 58/276.

- 48 Papers on the appointment of the Rolleston committee. Letter from Dr.J.H.E. Brock to Sir George Newman 24 January, 1924. Ministry of Health papers, MH 58/275.
- 49 Evidence of Mr.Pilkington Sargeant,President of the Pharmaceutical Society.MH 58/278.
- 50 HO 45/451408/27 22 Feb 1926.
- 51 See, for example, E.M.Schur, *Narcotic Addiction in Britain and America.The Impact of Public Policy*. (London,Tavistock,1963).
- 52 D. Downes, *Contrasts in tolerance: post war penal policy in the Netherlands and England and Wales* (Oxford: Clarendon Press, 1988).
- 53 S.E.D. Shortt, *Victorian Lunacy. Richard M. Bucke and the Practice of late nineteenth century Psychiatry*. (Cambridge, Cambridge University Press, 1986).
- 54 V. Berridge, 'AIDS and British drug policy: continuity or change?' in V. Berridge and P. Strong eds. *AIDS and Contemporary History*. (Cambridge, Cambridge University Press, 1993).

4 The History of British Psychopharmacology

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In 1974, the first steps were taken to establish what became the British Association for Psychopharmacology (BAP). The impetus for this did not come from the recognised centres of neuroscientific excellence within the UK – Oxford, Cambridge, Edinburgh. Nor did it come from the dominant psychiatric centre – the Maudsley Hospital/Institute of Psychiatry – indeed, to many it appeared that the ‘psychopharmacological revolution’ bypassed that institution. In this chapter, I will attempt to cover the background against which the development of the BAP took place and then briefly outline the changing situation of psychopharmacology in the UK since it was formed.

Origins

The roots of British psychopharmacology can be traced to a tradition of interest in neurophysiology, which was apparent as early as the eighteenth century in Edinburgh in the work of Cullen, Whytt, and others (French, 1969; Pinero, 1983). It flourished in the nineteenth century, with British contributions to neuroanatomy and physiology from Marshall Hall and Charles Bell (Bell, 1826) in the early years, Laycock and Carpenter in mid-century, and subsequently with the clinical work of Gower, Ferrier, and Jackson as well as the experimental innovations of Sherrington toward the end of the century (Clark & Jacyna, 1987). This tradition was continued in the twentieth century, particularly at Oxford and Cambridge in the work of Hill, Eccles, Adrian and Matthews. Indeed, the very dominance of the neurophysiological tradition (‘there is no field of science where British tradition has given a better demonstration of its virtues’ [Bacq, 1983]) may to some extent have inhibited developments in biochemical pharmacology that were a necessary prelude to the initiation of the psychopharmacological era (Richter, 1953; Bacq, 1983).

In the early years of this century, from within neurophysiology, Langley, working in Cambridge, had put forward a hypothesis regarding receptors and neurotransmitters (Langley, 1901). This notion, followed up by Langley himself and Dale, eventually led Clark (1932) in Edinburgh to his formulation of classical receptor theory, with its concepts of agonists, partial agonists, and antagonists, as well as affinity and intrinsic activity. Langley’s ideas were given flesh by Elliott’s

discovery of adrenaline (Elliott, 1905) and Dale's work on acetylcholine (Dale, 1914). While the credit for 'proving' that acetylcholine is liberated from nerve endings and acts as a neurotransmitter is usually given to Loewi, a great deal of the preparatory work for and subsequent capitalisation on Loewi's experiments was undertaken by Dale, Feldberg, and later Vogt at Cambridge (Dale *et al*, 1936; Dale 1936; see Bacq, 1983; Richter, 1989).

In the 1930s and 1940s, scientific efforts focussed on identifying the biochemistry of energy-supplying mechanisms in the brain and on the development of radioactive tracer methods (Richter, 1950), which laid the basis for subsequent post-war progress. Among the notable names of this period were Derek Richter, who initially worked at Cambridge, where he discovered monoamine oxidase and adrenochrome, and later at the Maudsley, but who during the critical years of 1950-1970, worked at the neuropsychiatric institute in Cardiff and later ran a Medical Research Council (MRC) neuropsychiatric unit at Carshalton. Richter played a part in training many of those who were subsequently notable in psychopharmacological research in the 1960s, 70s, and 80s and influencing others, through the medium of workshops and seminars held under the auspices of the Medical Research Council or Mental Health Foundation (Richter, 1950 & 1957; see also Tanner, 1953; Sandler & Healy, 1994).

Others who were influential included Quastel, who worked on amine oxidases and intermediate metabolism (Weil-Malherbe, 1953; Richter, 1989; Todrick, 1991), Blaschko (1939, 1952), who collaborated with Richter on the discovery of monoamine oxidase and later worked on the pathway for synthesis of adrenaline (Richter, 1989; Bacq, 1983), as well as Bulbring (1944) and Burn (Burn 1950; Bulbring and Burn 1941) who did a great deal of early work on adrenaline, noradrenaline, and cortisol, and McIlwain and Rodnight, who worked on aspects of intermediate metabolism. Others were Harris (1953), Reiss (1953), and Weil-Malherbe (1953), who investigated the endocrine correlates of psychiatric disorders.

During the 1940s and early 1950s, work in areas that were later to come together to form psychopharmacology was reported in settings such as the British Physiological Society, the British Pharmacological Society, and the Biochemical Society (Steinberg & Healy, 1996). This had a physiological and neurochemical basis, with a secondary focus on drugs, in that these were used as tools to investigate primary processes rather than being investigated as objects of interest in their own right. It was only with the development of psychotropic compounds and the large-scale expansion of the pharmaceutical industry after World War II that perceptions changed. The orientation of meetings then shifted from being primarily neurophysiological to having a greater interest in the nature of the differences between compounds and the possible therapeutic applications of such differences. With these changes, the institutions and journals that would support such developments also emerged. One of the earliest publications was the *Journal of Neurochemistry*, established in 1956 by Richter, who also at this time set up the first charity devoted to the support of research into mental illness – the Mental Health Foundation (Richter, 1989).

While the discovery of LSD in 1943 and the introduction of chlorpromazine clinically in 1954 are seen internationally as the key events in initiating the psychopharmacological era (Hordern, 1968; Ban & Hippius 1989 & 1992), two pronouncements by major scientists were felt by those working in British

neuroscience in the 1950s to mark a sea-change. One was the conversion of Eccles, in 1950, to an acceptance that chemical means of neurotransmission must be of some functional importance (Bacq, 1983). The other was Gaddum's statement that given the similarities between LSD and 5HT and the presence of 5HT in the brain, its role there might involve keeping us sane (Gaddum, 1953; Sandler & Healy, 1994).

The evolution of psychopharmacology from the 1950s will be discussed under five headings – Biochemical Psychopharmacology, Chemical Pathology, Pharmacopsychology, Clinical Trials Methodology, and Clinical Psychopharmacology. Psychopharmacology today overlaps very heavily with biological psychiatry and neuroscience, and in this age of international collaborative projects and scientific media, it is not easily possible to dissect developments in British psychopharmacology from those happening elsewhere. There will, therefore, be some reference below to non-British and non-psychopharmacological research.

Biochemical Psychopharmacology

In the early 1950s, the prospects for any development of a rational psychopharmacology, based on knowledge of central nervous system neurobiology, appeared poor. The CNS was considered too complex to be approached scientifically, although work on the physiology of the brain by Morruzzi, Magoun, Killam, Kety and others in the United States since the late 1940s had begun to change perceptions. However, in the early 1950s, the establishment of chemical neurotransmission in the brain led to an increasing pace of change. There have been clear differences in the development of each of the main neurotransmitter systems.

Acetylcholine (ACh)

British physiologists made the main contributions to early knowledge about acetylcholine (Feldberg 1950; Bacq, 1983). It had been first identified in the brain by Dale (1936), its regional distribution was shown by Feldberg & Vogt (1948), the effects of cholinesterases to modify its actions by Adrian *et al* (1947), and it was demonstrated by Richter & Crossland (1949) that variations in its availability in the CNS could be correlated, albeit crudely, with emotional states. Somewhat surprisingly, then, given this headstart, developments with ACh have not been of any great historical importance within psychopharmacology, despite the fact that cholinergic compounds have the clearest psychotropic effects.

Throughout the 1940s, there had been vigorous debates on the role of ACh in neurotransmission between those in favour of chemical transmission and those convinced that electrical transmission was all-important (Bacq, 1983). This echoed the late nineteenth-century debate on the role of synaptic junctions, which pitted those who believed in neuronal continuity against those who argued for contiguity (Blaschko, 1957). While the battle was effectively settled in the early 1950s, resistance to the idea of chemical transmission can be found as late as 1961 in Grey Walter's popular book *The Living Brain* and 1963 in McLennan's monograph on Synaptic Transmission (McLennan 1963).

However, no sooner had Eccles conceded that chemical transmission was of importance, than the 'neurochemists' found themselves impressed by how little ACh neurotransmission appeared able to explain, leading them to suppose that 'substances other than acetylcholine, of equally wide or wider distribution, may play a complementary part' (Elkes 1953). Ever since, it has seemed to be a characteristic of psychopharmacology to lose interest in established neurotransmitters, and to suppose that the most recently discovered transmitter or receptor will unlock the remaining secrets of the black box.

With the triumph of the neurochemists, the research programme of psychopharmacology was set on a relentlessly empirical course. As such, there was an inevitable tension between it and the classical research programmes of Oxford, Cambridge, and the Maudsley, in which theory and authority dictated which experiments would happen next. For this reason, neurophysiology also lost its grip within psychopharmacology, even though as late as 1957, in the first international psychopharmacology meeting, the neurophysiological techniques of Bovet, Morrucci, Bradley, Killam, Monnier, and others were the dominant force in the emerging discipline (Garattini & Healy, 1996). By the late 1960s, however, although a range of isolated psychophysiological techniques such as the sedation threshold, galvanic skin response and sleep stage recording were still in use (Claridge & Healy, 1994) and lip-service was still paid to the importance of psychophysiology, the physiologists had been all but sidelined.

Two other factors are of note about the demise of ACh. Essential technical developments to permit further investigation of its role in the cerebral economy did not happen. Paper chromatography had been introduced by Martin & Synge in Cambridge at the end of the 1930s, and spectrophotometry was available from the early 1940s, but neither of these techniques are sufficiently potent to track cholinergic function with the requisite sensitivity. (This problem has still not been solved satisfactorily). Another factor was that, about 1965, the known neurotransmitters, as though by an act of informal collective consent, were assigned each to a specific disorder – catecholamines to mood disorders, 5HT to anxiety, dopamine to psychosis, and ACh to dementia. As cholinergic compounds seemed unlikely to have any clear therapeutic effect in dementia in the short term, interest in ACh appears to have suffered accordingly, although there has been a rich tradition of using cholinergic compounds as probes to test memory functions in a range of pharmacopsychological paradigms.

5HT

The chemical structure of serotonin was established by Rapoport in 1949, and it was subsequently identified in the brain by Twarog & Page in 1953. The discovery of the psychotropic effects of LSD in 1943, followed by recognition of the structural affinity between 5HT and LSD, led to great interest in this neurotransmitter. Gaddum & Picarelli (1957) made an early attempt to distinguish between 5HT receptor types. The further development of 5HT psychopharmacology was made possible by co-incident technical advances. In the mid-1950s, Udenfriend, Bowman, & Brodie introduced

the spectrophotofluorimeter; this replaced the spectrophotometer, permitting the accurate detection of much smaller amounts of endogenous compounds within the brain and fluctuations in response to challenges with psychotropic compounds (see Carlsson, 1987). Until then, it had not been possible to refute conclusively the contention put forward by Erspamer, the discoverer of 5HT, and others to the effect that brain 5HT derived simply from the passage of blood through the brain (Garattini & Healy, 1996). By the end of the 1950s, 5HT appeared to many to be emerging as the most important neurotransmitter (Stafford-Clark, 1957).

A group established in Birmingham by Elkes, including Bradley and Keay was at the forefront of research on 5HT during the 1950s. Their work involved monitoring the effects of LSD on behaviour, by implanting microelectrodes in the brains of ambulant animals and more classic electrophysiological experiments (Elkes, 1970; Bradley unpubl, interview). The impact of this work was such that when Ernst Rothlin visited the UK to seek British support for the establishment of the Collegium Internationale Neuropsychopharmacologicum (CINP), he came first to Birmingham.

Bradley, whose career has spanned the era thus far, has been in many respects the representative transitional figure; his early work was elegantly classical and within the mainstream neurophysiological tradition; he was a founder member of the CINP. He later pioneered new techniques such as microiontophoresis, took part in establishing the BAP, and was finally in the late 1980s the chairman of an international committee drawn together to standardise 5HT receptor nomenclature – a pressing problem in the face of a cascade of new receptors triggered by technical developments during the 1980s.

Between 1960 and 1980, however, there were increasing difficulties in maintaining interest in research on 5HT, as the ligands available were non-specific and LSD was proscribed. It was not until 1980 that the necessary psychopharmacological tools were in place to explore 5HT receptor pharmacology in greater detail. The critical breakthrough that catalysed the field into its current state of hyperactivity stemmed from a distinction between 5HT-1 and 5HT-2 receptors drawn by Peroutka & Snyder in 1980, on the basis of radioligand studies. Since then, there has been both an identification of an ever increasing number of 5HT receptors and a synthesis of ligands capable of binding to these, thereby permitting an exploration of their physiological and behavioural correlates.

In contrast to the slow progress of 5HT receptor pharmacology, the availability of chromatography and spectrofluorimetry permitted the metabolism of both 5HT and catecholamines to be investigated. Work on tracing the metabolic pathways of both these neurotransmitters progressed rapidly during the late 1950s and in the 1960s, with Axelrod and Brodie in the US and Sandler and Iversen particularly involved in the UK (Sandler & Healy, 1994). This line of development subsequently led to distinctions between monoamine oxidase A and B, in which Sandler and his colleagues played an important part, as well as between P and M forms of phenolsulphotransferase. The identification of trace amines such as the phenylethylamines, phenylethanolamine, tyramine, tryptamine, and beta-carboline, was also pioneered by this group (Sandler & Healy, 1994).

Catecholamines

Interest in the role of catecholamines in nervous disorders was stimulated by the identification of noradrenaline in the brain by Vogt (1952 & 1954), working at the Babraham Institute of Animal Physiology near Cambridge. At the same time, the metabolic pathways by which adrenaline and noradrenaline were broken down were being clarified by Armstrong, Axelrod, Brodie, Kety, and others in the United States, while techniques to measure the levels of catecholamine metabolites in bodily fluids were developed by Sandler, Ruthven, and colleagues in London (Sandler & Healy, 1994).

A demonstration that imipramine had the opposite effects on blood 5HT levels to monoamine oxidase inhibitors played some part in stimulating Axelrod's conception of a monoamine reuptake mechanism (Todrick, 1991). Subsequently, work by Iversen on catecholamines led to a distinction between high-affinity and low-affinity uptake mechanisms (Iversen, 1967). Further research was stimulated by the elaboration of a catecholamine hypothesis of depression (Schildkraut, 1965; Bunney & Davis, 1965) and by the mapping, in Sweden, of monoamine tracts in the brain by Fuxe & Dahlstrom using the Falck-Hillarp fluorescence method (Carlsson, 1987 & 1990; Carlsson and Healy 1996). The catecholamine hypothesis, along with the identification of reuptake mechanisms as a possible site of action for antidepressant drugs, together with distinctions between monoamine oxidase A and B, which emerged in 1969/70, gave considerable dynamism to the field of catecholamine pharmacology – a dynamism that had been lost in 5HT work.

Further impetus came from the development of radioligand binding techniques in the early 1970s (see Stadel & Lefkowitz, 1991 for a chronology of developments). These became available for catecholamine receptors before any others, permitting an identification of the number and functional state of receptors, which in turn laid the basis for further developments in the field. Subsequent advances were dependent on the availability of radioligands that were specific to receptor subtypes, and a much greater number of suitable radioligands were available for catecholamine receptors than for 5HT or ACh. This in turn supported the use of these compounds in animal models to dissect behaviour and a proportion of these ligands were subsequently found capable of further development as therapeutic compounds. The relevance of these developments in receptor technology was noted very early by Ashcroft *et al* (1972), when they reformulated the catecholamine hypothesis of depression in terms of receptor abnormality. This influential reformulation laid the basis for a large number of research programmes aimed at elucidating the neurochemical correlates of the affective disorders.

Catecholamine psychopharmacology was also given considerable impetus with the identification of the role of dopamine depletion in Parkinson's disease and the success of l-dopa replacement strategies. The principal contributions to dopamine psychopharmacology have perhaps come from Carlsson's group in Sweden and from Seeman, Snyder, and others in the United States. British contributions have centred on developments in monoamine oxidase psychopharmacology involving Sandler, Callingham, and Tipton. Woodruff and colleagues were involved in early receptor pharmacology, attempting to distinguish between D1 and D2 receptors – work that was taken further by Marsden, Jenner and colleagues in the later 1970s and 1980s.

While British developments in dopamine receptor binding methodology have not been as notable than they have been for other receptors, inputs from biological psychiatry such as Crow's (1980) formulation of Type I and Type II schizophrenic processes, with the former being tied to abnormalities of the dopamine system, have proved extremely influential. These laid the basis for world-wide interest in exploring the neurochemistry of and functional correlates of the dopamine system. Indeed, Crow's reformulation of the dopamine hypothesis of schizophrenia so much captured the imagination that it has remained in place long after the original formulations were abandoned by their authors (Snyder, 1982; Carlson, 1987; see Healy, 1991).

GABA, Neuropeptides & Excitatory Amino Acids

Early experiments on the capacity of brain slices to oxidise glutamic acid (Weil-Malherbe 1936) led to the prescient suggestion that this amino acid might have a role in epilepsy (Richter, 1950). Despite this initial stimulus, owing to lack of techniques and an appropriate conceptual framework, developments in the fields of GABA, excitatory amino acid, and neuropeptide neuropharmacology have only become systematic since the 1980s.

Perhaps the seminal discovery in world terms was that of a group of endogenous peptide neurotransmitters in the brain – the enkephalins – by Hughes *et al* (1975) in Aberdeen. This finding had effects far beyond the confines of opiate psychopharmacology (Steinberg & Healy, 1996; Hughes & Healy 1996). One consequence of this discovery was to lay to rest a ghost that had hung around psychopharmacology since Jaspers (Healy, 1993), who proposed that psychotropic drugs were alien compounds, which poisoned brain function, and that the art of their administration was in fact the judicious application of poisons. However, the demonstration that these 'same poisons' were necessary for brain functioning challenged such ideas.

A second effect was to put paid to a mechanistic principle, first enunciated by Dale, that each nerve cell uses one and only one neurotransmitter. The discovery of endogenous opiates, and subsequently other neuropeptides, coincided with observations that more than one neurotransmitter might be present in a single neurone. This led to the introduction of concepts such as neuromodulation, fostered distinctions between fast and slow neurotransmission, and provided a significant impetus to the further development of GABA, excitatory amino-acid, and neuropeptide psychopharmacology. In the process, biochemical psychopharmacology was transformed from what had been a rather two-dimensional, mechanical science to a much more complex and delicately nuanced field.

Chemical Pathology

The immensely influential work of Alzheimer and his colleagues in Germany in the early years of the century made it clear that every mental hospital needed an associated pathological laboratory. By the 1920s, the pressure to have such laboratories had developed to the extent that they were established in hospitals

from Denbigh in North Wales, to Crichton Royal in Dumfries and Runwell in Essex, as well as in larger centres such as Cardiff and Bristol. The fruits of these developments came in a series of publications in the 1930s, such as those of McCowan & Quastel (1931), Strom-Olsen (1932), Weil-Malherbe (1936), Weil-Malherbe and Bone (1951). Initial contributions focussed on determinations of blood sugar and glucose tolerance. The pinnacle of mental hospital laboratory achievements, though, was in 1960, when Todrick and colleagues at Crichton Royal reported that in contrast to an MAO inhibitor, imipramine lowered blood 5HT levels – the first demonstration of what is now accepted to be an important aspect of the mode of action of tricyclic antidepressants (Marshall et al, 1960).

The development of mental hospital laboratories also laid the basis for an increased interest in endocrine aspects of psychiatric disorders, and a series of research programmes were established in the 1940s, involving Hemphill and Reiss in Bristol, Harris *et al* at the Maudsley, and Happold *et al* in Leeds (Hemphill & Reiss, 1950; Reiss et al, 1951; Reiss, 1952; Happold, 1953; Weil-Malherbe, 1953; Harris, 1953). These focussed on the role of steroids in mental illness, and on the mechanisms integrating the interactions between various elements of the steroid system, as well as their response to behavioural challenges. This work was given a conceptual focus in the mid 1950s, when Selye elaborated the concept of a stress reaction. The search for what is distinctive about the steroid system in the affective disorders again came to prominence with the introduction of the dexamethasone suppression test for depression in 1976 (see below).

A very similar set of metabolic and endocrine investigations had been undertaken in patients with schizophrenia, with papers by Quastel, Weil-Malherbe, Reiss, and others (see Richter, 1957; Sands, 1957). Metabolic and clinical studies were dominated at this period by the work of Gjessing on periodic catatonia, later pursued by Jenner at Birmingham and Sheffield, and Hullin in Cardiff and Epsom, though without any significant outcome. Endocrine studies were given a particular focus during the period by the use of insulin coma as a treatment for schizophrenia (Sands, 1957), but again little of note emerged.

In 1952, Harley-Mason (Osmond & Smythies, 1952) suggested that schizophrenia might result from an abnormal transmethylation of catecholamines, yielding dimethoxyphenylethylamine (DMPEA). In 1954, Hoffer et al reported that adrenochrome could cause psychotic manifestations similar to those seen in schizophrenia. Adrenochrome had first been isolated by Green & Richter (1939), who had determined its chemical constitution (later found to resemble LSD and other hallucinogens), and shown that it was produced in the brain and other tissues. These twin hypotheses gave rise to a variety of 'toxic psychosis' proposals, which generated a great deal of research activity during the latter half of the 1950s, culminating in the discovery of 'pink spots' in the urine of individuals with schizophrenia in 1962. This spot story gave rise to a great deal of excitement but subsequent disappointment, as it became apparent that it was an artifact of treatment and of chromatographic extraction.

The modern era in chemical pathology began in the latter half of the 1950s with work by Sandler and others in the UK, along with Kety, Axelrod, and Brodie in the US, to map out the metabolic pathways of monoamines and develop techniques to estimate these metabolites in bodily compartments. Chemical pathology was therefore in a much better position than biochemical psychopharmacology to advance rapidly, and it did. By 1958, Sandler & Pare had

effectively formulated and tested the amine hypothesis of depression, and failed to find evidence in favour of it (Pare & Sandler, 1959).

These developments gave rise to a number of studies aimed at determining the metabolic and endocrine states of individuals who were depressed, through investigation of cerebrospinal fluid (csf), blood, and urine. The investigators included Ashcroft, Bridges, Crawford, Jenner, Gibbons, Dawson, Blackwell, Shaw, Curzon, Rodnight, and Coppen, many of whom were later prominent in the BAP. The work of Coppen *et al* at West Park was particularly significant, combining clinical trials on the prophylactic effects of lithium with laboratory studies on depressed patients. In 1963, following a study of the effects of adding tryptophan to an MAO regimen, Coppen postulated a role for 5HT in the affective disorders (Coppen & Healy, 1996). Later (1967), Coppen reviewed the early metabolic work in depression. While much of the biochemistry even then seemed dated, its appearance, along with a first adumbration of a 5HT hypothesis of affective disorders, posted a message of changing times. The impact of this paper appears to have been almost as great as the formulation two years earlier of the catecholamine hypothesis of depression (see also Coppen 1972).

The study of biological psychiatry became respectable and perhaps fortuitously, this coincided with the establishment in Britain of a number of chairs in psychiatry and the appointment to some of these of individuals whose reputations had been made in biological psychiatry (Healy, 1987). This trend has been enhanced as funding for non-biologically oriented research has become harder to obtain, so that universities seeking funds and research ratings have increasingly opted for psychiatrists with biological interests.

The outcome of research on the chemical pathology of psychiatric disorders has, however, been disappointing. While the revised amine hypothesis proposed by Ashcroft *et al* (1972) commanded the field for the better part of 20 years, and a large number of research teams devoted considerable amounts of time and money to the measurement of peripheral alpha-2 adrenergic and beta adrenergic receptors, there has been no clear outcome to all this effort (Healy & Paykel, 1992).

The other major areas of research were tritiated imipramine binding and the dexamethasone suppression test (DST), both of which became 'fashionable' in the 1980s and generated large research enterprises, but with disappointing results. Coppen *et al* (1978) were among the first to report on abnormalities in platelet 5HT uptake in depression, which has proven to be one of the most replicable findings in biological psychiatry (Healy & Leonard, 1987). It has, however, been bypassed by fashion, in part, because of the advent of radiolabelling – since radiolabelled antidepressants bind to 5HT reuptake sites, it was assumed that assays of such binding sites would be functionally more appropriate than assays of 5HT reuptake itself. No clear results, however, have emerged from a wealth of research in this area (Healy & Paykel, 1992); the methodological confounds have been comprehensive, and in the cases both of this and the DST have militated against 'the genesis of scientific facts' (Fleck, 1979).

Psychiatrists, pharmacologists, and others who have contributed to the fields of neuroendocrinology and post-mortem brain work include Deakin, Horton, Ferrier, and Dinan. Of great influence have been a group collected around Grahame-Smith at Oxford, who have looked at the behavioural

correlates of tryptophan administration and brain 5HT manipulation in both animals and humans. These have included Elliott, Cowen, Nutt and Goodwin, all of whom have since gone on to play important roles in British psychopharmacology. These researchers have helped advance the basic sciences involved in neuroendocrinology and post mortem brain work, but as yet, none of these endeavours have yielded results of clear relevance to either the affective disorders or schizophrenia. At present, the citing of biological marker studies, or the use of biological language too often appears to provide for artistic verisimilitude rather than genuine information (Healy, 1987).

Pharmacopsychology

The term 'pharmacopsychology' was coined by Kraepelin (1892) and referred to the inferences that could be made from measuring the effects of psychotropic compounds on cognitive function (Healy, 1993). He appeared to see the possibility of testing cognitive theories with pharmacological agents and of using tests to establish the effects of psychotropic compounds on daily functioning. This latter area attracted sporadic interest from the 1890s to the 1960s, with investigators looking at the effects of caffeine, nicotine, alcohol, and other compounds on a range of psychological tests (see Sherwood, 1993).

In 1948, Steinberg, an experimental psychologist, joined the Pharmacology Department in the University of London to work on psychological aspects of nitrous oxide and other psychotropic agents. In 1962, she was appointed a Reader in Psychopharmacology – the first such title in the world – and in 1972, she was appointed to the first Chair in Psychopharmacology in the world. Following early work on cognitive function tests in human volunteers, Steinberg became one of the first to use psychotropic agents to dissect animal behaviour. When Russell was appointed to the Chair in Psychology at the University of London, following Burt, he established an animal house, in which Steinberg and colleagues explored the effects of combining different classes of psychotropic drugs on animal behaviour. An early notable discovery was that amphetamine and barbiturate combinations had stimulant effects on behaviour that differed substantially from what might have been predicted (Steinberg & Healy, 1996).

Another line of pharmacopsychological development came from the influential personality theory erected by Eysenck (1947, 1957), on a basis laid by Jung, Pavlov, and MacDougal. He postulated that there are dimensions of personality corresponding to introversion and extroversion, as well as neuroticism and later psychoticism, and related these to physiological concepts such as reactive inhibition and to aspects of constitution such as autonomic system reactivity (Eysenck, 1957; Claridge, 1972). He embraced the possibility that the emerging psychotropic agents might critically test his model and made specific predictions regarding the effects that stimulant agents such as amphetamine, and depressant agents such as barbiturates would have on behaviour and aspects of cognitive function in different groups of neurotic disorders (Eysenck, 1957 & 1961). This coherent theoretical position led to his being a prominent participant at early CINP and other meetings in the late 1950s and early 1960s.

The demonstration of sedation thresholds by Shagass and of the effects of sedative agents on this threshold in different categories of neurotic disorder (Shagass and Naiman, 1956; Claridge & Healy, 1994) laid the basis for testing Eysenck's theories at the Maudsley and by Claridge in Southampton and later Glasgow (Claridge, 1970; 1972). While some early results supported his formulations and generated considerable interest, most studies failed to confirm them. This line of research was made more difficult by the proscription of amphetamines and barbiturates in the 1960s. In addition, Eysenck's theoretical framework had problems with the emergence of sedative antidepressants - which confounded the expectations of many researchers in different areas of psychopharmacology (see Brodie, 1965).

The notion of a pharmacological dissection of constitutional types was later taken up by Claridge (1972), who proposed that the schizophrenias might be viewed as 'nervous types', i.e. instances of a particular type of neurophysiological organisation. He argued that research on the cognitive effects of drugs and the dimensional basis of such effects might permit an investigation of proneness to psychosis, and provide indicators against which treatment could be titrated. Such views, however, fell out of favour and an update of the dimensional model (Claridge 1987) initially received a poor response (Claridge & Healy, 1994). A factor in this may have been the rise of the anti-psychiatry movement, as exemplified in the work of Laing. Whereas in the 1960s, pharmacopsychology had been a meeting ground where researchers such as Claridge and Lader collaborated with others on psychophysiological, psychosomatic, and neuropsychiatric work, in the face of the challenges posed by Laing, dimensional views of mental illness became suspect. From the point of view of biologically oriented psychologists, psychiatry retrenched into a hardline 'medical' model (Claridge & Healy, 1994; Claridge, 1994). Another factor clearly was the development of categorical views of psychiatric illness in America, as codified in DSM-III (APA, 1980).

However, work on dimensional models of psychoticism has contributed substantially to the development of notions such as schizotypy. In this form, psychoticism is at present re-emerging into prominence in both biological psychiatric research (linked to developments in genetics) and psychological research on schizophrenia, although current developments in the area appear to have slipped from their original biological moorings.

With the proscription of LSD in the late 1960s, the sidelining of amphetamines and barbiturates, and the general concern that developed about giving psychotomimetic or psychotropic agents to healthy volunteers, the field of pharmacopsychology was transformed. Work on humans became increasingly problematic. This situation was aggravated by rising problems with the indemnification and organisation of healthy volunteer studies, which first became a problem in the 1970s, when for legal and insurance reasons consequent on the changing climate of regulation after the thalidomide disaster, researchers within the pharmaceutical industry involved in drug development programmes were prohibited from testing out compounds on themselves (Healy & Watson, 1995). From there, the problem has spread to universities and other research settings, so that at present, it has become extremely difficult to do independent pharmacopsychological research. In the face of these developments, there was a switch to work with animals and to the development of behavioural biology,

which had become established at the University of London and other centres. This move was strengthened by the development of animal models capable of predicting antidepressant, anxiolytic, or antipsychotic activities from novel psychotropic compounds.

There have been three uses of animals within psychopharmacology. One has been in screening models, where the use of animals has sometimes appeared to have an assembly-line character. This has attracted criticism during the 1980s from animal liberation activists who, however, have often failed to distinguish this use from the development of sophisticated models of human behavioural disorders and ethopharmacology.

Using animals, Eysenck's model was developed by Gray, who introduced the concept of a behavioural inhibition model and more recently, models of latent inhibition have been used by Joseph *et al* at the Institute of Psychiatry. Susan Iversen, an early BAP President, played a key role in this area with her work on the role of the amygdala in behaviour and the effects of drugs on its functioning. There have, in addition, been a large number of animal models of anxiety and of depression developed by File, Handley, Leonard, Willner, and others. These have been constructed independently of the learning theory/Skinnerian traditions that had been a subject of early interest in relation to drug development (Leonard & Healy, 1996).

As animal houses grew in size and sophistication, a need emerged to refocus attention back on the behaviour of animals in behavioural settings. This had begun with Steinberg and Rushton in London but was picked up, particularly in Birmingham, by Chance, Macintosh, and Grant who studied the changes in animal behaviour in social and wild settings, brought about by sedative and other agents (Chance, 1968). This interest in behaviour in naturalistic settings led to the development of ethopharmacology. Notable British inputs to this field have come from Rodgers *et al* in Bradford as well as a very influential group centred on Herbert in the Department of Anatomy in Cambridge, which has included Everitt, Keverne, Robbins, and Hastings among others. In addition to substantial contributions to behavioural biology, this group have played a significant role in establishing Cambridge as a venue for BAP Summer meetings.

Animal studies have contributed invaluablely to a dissection of the interaction between drug regimes and behaviour that leads to drug dependence. Again Steinberg was an early worker in this field, her efforts being followed up by Stolerman, Kumar, and others (see Robbins and Stolerman 1990; Russell 1991; Brady 1993).

Returning to the original ambiguities within Kraepelin's notion of pharmacopsychology, a further field that has developed since the 1960s has been that of applied psychopharmacology. This was developed rigorously by researchers such as Oswald investigating the effects of psychotropic compounds on sleep parameters, and both Broadhurst and Nicholson who looked at their effects on adaptive tracking tasks in air-force personnel (Broadhurst & Healy, 1996). Hindmarch has investigated the effects of compounds on vigilance, reaction time, and daily living skills, which has involved the standardisation of tests that are pharmacosensitive and permit extrapolation from the test situation to daily living. While the theoretical coherence of these latter research programmes has been questioned, arguments drawn from the field of applied psychology are

increasingly the basis on which older compounds are replaced by newer ones. This area is therefore one of considerable significance.

Clinical Trials

Arguably the development of clinical trial technology was an even more significant scientific development than the generation of the new compounds themselves. In the early 1950s, Linford Rees carried out the first properly constituted double-blind, placebo-controlled trials in psychiatry (Rees & Healy, 1996). Subsequently, the first effective psychotropic compounds were introduced in France, following serendipitous observation and without controlled trials. Indeed, there was at the time little understanding of the necessity for such trials. It seems probable that only one or two psychiatrists in Britain, among them notably Rees and Hamilton, were then confident with the methodology involved and aware of the necessity for such approaches (Hamilton, 1988; Rees & Healy, 1996). Rees undertook a number of the early trials on other neuroleptics, antidepressants and anxiolytics, while Hamilton played a notable part in the process through the construction of the Hamilton Rating Scale for Depression.

Initially, British interest in clinical trials provoked surprise elsewhere in Europe (Rees & Healy, 1996). Even within the UK, there was a certain amount of incomprehension, with Eysenck (1990) remarking that Aubrey Lewis, for instance, had a very poor grasp of statistical methodology. The saga of whether insulin coma was effective or not in the treatment of schizophrenia did a great deal to persuade clinicians of the need for such trials; in the process, the canons of evidence in psychiatry were completely changed (Bourne, 1953; Shepherd, 1990; Rees & Healy, 1996; Broadhurst & Healy, 1996). It is still possible to introduce new medical or surgical procedures or new psychotherapies without evidence of demonstrable efficacy. Indeed, it is even possible to change the entire health system of the country without proof that the system to which one aspires will be more efficacious. However, the procedures which have been established around the development of pharmaceutical products have begun to infiltrate other areas of medicine, so that in the United States, for example, there has been a celebrated court case which hinged on the question of whether particular forms of psychotherapy have demonstrable outcomes (Klerman, 1990). It seems increasingly likely that insurance companies and purchasers will withdraw funding from procedures that do not have demonstrated rates of success.

The impact of clinical trial methodology has also a number of other effects. It has led, for instance, to a huge increase in the costs of bringing a drug to the market as, in addition to toxicological and other data, companies must provide evidence of efficacy. This increase in cost has contributed to a need for a sophisticated marketing of psychotropic compounds, which in turn has led to popular concerns about the pharmaceutical industry among prescribers and patients. Promotional activities are increasingly subtle, so that the holding of seemingly independent conferences or the publication of journal supplements on specific themes may be less disinterested than they appear (Healy, 1990, Healy, 1995 and below).

Clinical Trials, Marketing and Nosology

The development during the 1950s of what were essentially two groups of compounds, the antidepressants and neuroleptics, did a great deal to establish the Kraepelinian legacy in psychiatry – that there were essentially two mental disorders, manic-depressive illness and schizophrenia. This led to American psychiatry rejoining the European mainstream with the creation of DSM-III. More recent drug development, however, threatens to crack open the Kraepelinian synthesis, as companies have sought to market nosological entities as much as psychotropic compounds.

This process first became apparent following the 1965 Medical Research Council multi-centre trial, which compared electro-convulsive therapy with imipramine, phenelzine, and placebo and found phenelzine no better than placebo (MRC 1965). This result combined with concerns about the 'cheese effect' of MAOIs (Blackwell et al, 1967) – which in retrospect appears to have largely been a problem of tranylcypromine use (Pare, 1985) – and concerns about their hepatotoxicity, led to a marked drop in their use, despite impressions on the part of a number of eminent clinicians that the MAOIs were efficacious antidepressants. The companies involved in their marketing attempted to reposition the MAOIs as therapies for phobic or atypical depressions – an attempt that perhaps extended the shelf-life of concepts like reversed functional shift depression, phobic depression, and hysteroid dysphoria (Healy 1990).

The 'marketing' of nosological entities became clearer with the development of obsessive-compulsive disorder (OCD) as an indication for clomipramine. This compound, developed in 1964, initially appeared somewhat more toxic and not obviously more effective than other tricyclic antidepressants. However Beaumont, the Medical Director at Geigy (UK), noted reports of its usefulness in phobic and obsessive disorders. Geigy sponsored a number of studies on the use of clomipramine in these disorders, and in so doing established OCD as an indication for clomipramine. This development pathway has subsequently been followed by the selective 5HT reuptake inhibitors (Beaumont & Healy 1993).

As often happens in medicine, the availability of treatment leads to an increase in recognition of a disorder that might benefit from it; current estimates are that OCD is much commoner than was formerly thought. Studies in the USA indicate that upwards of five million people, there, may have the disorder (Freeman, 1992). Thus, OCD has emerged from being a rather infrequently recognised condition to one that may be at least as common as schizophrenia. There is increasing debate about its classification among the phobic disorders, and old affinities between it and paranoia are again being recognised (Fear et al, 1995). It would appear, therefore, that what was initially a 'marketing ploy' may in due course lead to a radical re-classification of psychiatric disorders (Fear et al, 1995).

A similar development has occurred in the case of alprazolam and panic disorder. The development of a triazolobenzodiazepine by Upjohn in the 1970s ran into emerging problems with benzodiazepines generally. To assist the marketing of this compound, Upjohn funded a number of studies to look at the efficacy of alprazolam for panic disorder (Healy, in press). The term 'panic disorder' had been coined by Klein in 1964, although comparable states had been recognised before that (e.g. phobic anxiety-depersonalisation state).

It was included in DSM-III in 1980 (APA, 1980), at a time almost perfectly suited to Upjohn, whose efforts to market alprazolam brought it to popular consciousness.

The examples of clomipramine for OCD and alprazolam for panic disorder may well be replicated by a marketing of the newly developed reversible MAO inhibitors for social phobia. It is possible that in this process, social phobia, a disorder that has hitherto been neglected in the West but is recognised as being extremely common in the Far East and especially in Japan, will be found to describe a condition that occurs commonly here also (Healy 1995). Such a demonstration would point to a role psychotropic agents may play in the dissection of the cultural construction of mental illness.

Clinical Trials & Science

As noted, one of the first multi-centre trials was held under the auspices of the Medical Research Council, in 1965. Few independent trials have been undertaken since then, either in Britain or elsewhere, possibly because clinical trial research is perceived as being comparatively well-funded. However, trials organised by the pharmaceutical industry are aimed at obtaining regulatory approval, rather than settling scientific issues. While the industry has refined its methodology, so that trials are now concerned with issues of long-term efficacy and relapse prevention, there is a perception in both Europe and the US that if differences are to be discovered between antidepressants and between antipsychotics, independent trials will be required (Garattini, 1996).

One significant development, though, has been the establishment of the Cochrane Centre in Oxford and the notion of systematic reviews of all randomised controlled trials (Chalmers *et al*, 1992). This British initiative, which is now being copied worldwide, aims at pooling data in a manner that may allow the detection of significant differences that individual trials have not had the power to reveal (Adams & Gelder, 1994).

Clinical Psychopharmacology

Clearly, by virtue of contributions to clinical trials methodology, British involvement with the development of clinical psychopharmacology has been considerable. If, however, clinical psychopharmacology is defined as a discipline requiring expertise regarding pharmacokinetics, pharmacodynamics, drug interactions, and adverse events, the situation is different. There seems to be something of an implicit assumption that anyone who is a psychiatrist is *ipso facto* a clinical psychopharmacologist; quite clearly, this is not the case.

Strictly speaking, the only British clinical psychopharmacologist has been Malcolm Lader. As a trainee at the Institute of Psychiatry, Lader co-authored the first British textbook of clinical psychopharmacology (Shepherd *et al*, 1968). He was subsequently appointed Reader in Clinical Psychopharmacology in 1973 and to the first Chair of Clinical Psychopharmacology in the UK in 1978. His work has involved measuring the effects of psychotropic agents on psychophysiological measures and on cognitive function. More recently, with Tyrer and Ashton, he

has been involved in mapping the boundaries of benzodiazepine dependence (Lader & Healy, 1996).

A number of other clinicians have taken an interest in the emerging psychotropic drugs and their implications for clinical practice. Shepherd, a foundation member of the CINP, was involved in early trials of reserpine in depression (Davies & Shepherd, 1955), a notable study of the impact of neuroleptics on inpatient stay (Shepherd, 1990), and the M.R.C. trial in 1965. Since then, his interests were more in the non-specific factors brought to every act of prescribing by both patients and doctors (Shepherd, 1990).

Another notable figure was Roth, who with co-workers in Newcastle, drew attention to a distinction between endogenous and reactive depression. While this was based on clinical and phenomenological criteria, the introduction, around 1960, of the first antidepressants, which appeared to be more effective for endogenomorphic forms of depression, helped buttress the distinctions and internationalised the Newcastle formulations. Newcastle during this period also proved a fertile training centre for researchers later to be influential in the BAP and other settings such as Kiloh, Garside, Brandon, and Fahy.

During the 1970s, Paykel amassed a large database of subjects, who had participated in clinical trials and other research, which formed the basis for studies on the classification of depression and the prediction of outcome. He described a number of depressive clusters, and challenged prevailing views that particular clusters were differentially responsive to particular groups of antidepressants. He and others have subsequently investigated the incidence of and phenomenology of general practice depression and its responsiveness or otherwise to antidepressants. His work, along with that of Goldberg, has helped to bring about a considerable change in professional and public awareness of depressive illness.

A further notable figure has been Montgomery, who helped develop the Montgomery-Asberg rating scale for depression, which has become an internationally used instrument. He played a critical part in establishing the responsiveness of OCD to clomipramine and other 5HT reuptake inhibitors (Beaumont & Healy, 1993), in highlighting the existence of recurrent brief depression, and in looking critically at the question of long-term treatment of depression (Montgomery & Rouillon, 1993). He has taken a leading role in involving the BAP in the generation of consensus statements on treatment with psychotropic drugs and on how their effects may be appropriately investigated.

Psychopharmacological Politics & Institutions

When the first steps were taken to establish the BAP (Brandon *et al.*, 1974 a,b,c; Wheatley & Healy, 1994), none of those involved came from Oxford, Cambridge, Edinburgh, or the Maudsley. This along with the fact that the original proposal came exclusively from clinicians caused a considerable stir (Beaumont & Healy, 1993; Sandler & Healy, 1994; Wheatley & Healy, 1994). However, as reviewed here, it seems notable that a range of institutions from the Crichton Royal in Dumfries to Queen Charlotte's Maternity Hospital in London played important roles in the emergence of the discipline. At a critical time in the 1940s and 1950s, Cardiff was influential owing to the work and influence of Richter, Quastel, and

McCowan. Birmingham was perhaps the key centre during the 1950s, after Elkes was appointed to a Chair in Experimental Psychiatry there, in 1951, and recruited Bradley, Keay, Crammer, Jenner, and others (Elkes 1970). This group linked up with a research programme involving Chance, MacIntosh, and others at the Uffculme Clinic to make for a dynamic mass of researchers (Leonard & Healy, 1996). In the 1960s and 1970s, the most significant discoveries and hypotheses came from Aberdeen, West Park, and Northwick Park.

While one outlet for such research was the CINP, which has held biennial meetings since 1958, this organisation alone failed to meet the range of psychopharmacological need. The Czechs, Scandinavians, Germans, and Americans had set up national associations of psychopharmacology by 1960 (Healy, 1993). By the early 1970s, it was clear to some that a British Academy was needed 'to further clinical and experimental research in psychopharmacology, improve the standards of psychotropic drug evaluation and have a policy in relation to the pharmaceutical industry' (Brandon *et al*, 1974a,b,c). The initial proposal appeared as a letter to the *BMJ*, *The Lancet* and the *British Journal of Psychiatry* from David Wheatley, Alec Coppen, Anthony Horden, Norman Imlah, Sidney Brandon, Alec Jenner, David Shaw, and Max Hamilton. The first movers of this letter were Wheatley and Hordern, prompted to action in part by Frank Ayd (Wheatley & Healy, 1994), although others had entertained a similar idea (Beaumont & Healy, 1993).

The letters received replies of support from 129 interested parties and a meeting was held on April 22nd 1974 (Wheatley 1974; BAP 1974). However, opposition to the proposals built up from over 100 basic scientists and clinicians; this crystallised around Bradley and most notably involved Bradley, Lader, Kumar, Stolerman, and Crow (Stolerman, 1995; Lader & Healy 1996; Bradley *pers comm*). A letter to *Nature* 'denouncing the Academy' was threatened. This conflict led to two stormy meetings at the Royal Society of Medicine (RSM) on the 22nd and 23rd of November 1974. At these meetings, Hamilton played a key part to create a society that had room for biochemical pharmacologists, behavioural biologists, and experimental psychologists, as well as clinicians. He did so, according to many of those involved, through a mastery of procedure and an insistence on focussing on issues rather than personalities.

A number of arguments were put forward against the association as it was initially conceived which made for heated exchanges over the two meetings. One was that an association predicated on the conduct of clinical trials could not represent the breadth of scientific work taking place that could properly be called 'psychopharmacological'. The cynical version of this argument was that a clinical trials association was simply a vehicle to cream off the funding that went with drug trials (Brandon, *pers comm*; Lader & Healy, 1996). A second argument, voiced by Crow, was that if real science was the aim, it would be better for those concerned to join the appropriate 'properly' scientific society, such as the British Pharmacological Society or the Physiological Society. Of some relevance to both of these arguments is the fact that the proposal appeared in clinical journals and not, for example, in *Nature*, where it might have attracted the attention of more basic scientists. A further argument concerned the original proposal to have a closed society (Lader & Healy, 1996). This, it was suggested, would ultimately be detrimental to the development of a broadly based neuroscientific research enterprise in the UK. That point was conceded.

A number of these arguments had a subtext, which was that centres of academic excellence, and in particular the Maudsley, had been excluded. The instigators of the proposed academy were perceived, in some quarters, as being a group of 'provincial' clinicians, including a general practitioner, given respectability by the inclusion of Hamilton. The 'exclusion' of centres of academic excellence, however, may seem less surprising in the light of the research reviewed in this chapter. It seems clear that there was a considerable degree of confidence, born from a background of substantial achievement, behind the move to form a new association. The advent of clinical trials, with British mastery of the methodology, may have done something to consolidate this confidence and to disperse 'biological' research around the country. Those involved initially in the formation of the BAP were among those who had participated most actively in chemical pathology research and clinical trial work during the 1960s.

So far as the 'exclusion' of basic scientists is concerned, when compared with psychiatrists interested in biological research, these were comparatively well served. Their major societies, such as the Biochemical Society, had neurochemistry or related sections. The Brain Research Association (BRA) had been formed by Dobbing and others in the mid 1960s as an interdisciplinary forum for neuroscientists (Richter, 1989; Rose, 1993). This perhaps headed off the need among neuroscientists to initiate another academic forum. It is of some interest that the BRA also had a predominantly 'peripheral' membership (Leonard & Healy, 1996).

The history of the BAP can only be understood with reference to the Royal College of Psychiatrists (RCP), which had only been formed in 1971 (Howells, 1991). The RCP has many speciality sections, but it did not then and still does not have one for biological psychiatry. Both the RCP and the Maudsley were perceived by many of those involved in forming the BAP as being dominated by social psychiatry issues; it was felt, accordingly, that key funding agencies were less likely to favour biological research, and that this needed to be redressed. Some of those involved in forming the BAP believed they were, in essence, establishing a biological psychiatry college. What emerged was something rather different, although in practice it has remained all but impossible for the BAP to take political or educational initiatives without reference to the RCP.

In the event, the British Association for Psychopharmacology was formed. A constitution was drawn up by George Beaumont and Max Hamilton, and informal arrangements were put in place that guaranteed a role for both clinical and basic scientists by limiting the period of time for which office could be held and rotating key offices between both groups. Membership has been divided approximately equally between clinical scientists, basic scientists, and industry clinicians and scientists. Hamilton became the first president and he has been followed by Coppen, Bradley, Sandler, Iversen, Paykel, Lader, Leonard, Montgomery, Everitt, and Deakin. At present, BAP has a membership of approximately 600, which makes it one of the largest national psychopharmacology associations.

In contrast to the expectations of many, it has not become dominated by the pharmaceutical industry. In contrast to the CINP, which was established in the main by basic scientists but whose trajectory of development has taken

it increasingly into clinical areas, the BAP has moved from being established at the instigation of clinicians to being increasingly oriented to basic science issues. Indeed, it has done so to the point where there are complaints that it has lost contact with clinical practice (Beaumont & Healy, 1993; Wheatley & Healy, 1994). In this respect, its evolution resembles that of the American College of Neuropsychopharmacology (ACNP), while the European College of Neuropsychopharmacology (ECNP) may be following the CINP model. This trajectory of development may owe something to a controversy around an annual meeting in 1984 (Beaumont & Healy, 1993), which was scheduled to be held in the St Pierre Park Hotel in Guernsey. This venue was felt to be too costly for basic scientists and students and afterwards it was decided to switch meetings from hotels or dedicated conference centres, which by virtue of cost only permit access to clinicians or senior scientists. Cambridge and other universities have been chosen instead, and bursaries have been established to assist non-clinical scientists and post-graduate researchers to participate.

The original arguments against the exclusion of non-clinical scientists centred on the rather obvious need to include some scientists who knew something about pharmacology. Latterly, however, non-clinical participation in the BAP has been from neuroscientists, many of whom know little more about classical pharmacology than the clinicians. A commonly heard criticism is that symposia have become too heavily neuroscience-oriented. Similar tensions within ACNP led to the formation in 1993 of the American Society of Clinical Psychopharmacology (Klein & Healy, 1996). Comparable developments are possible within BAP.

Other Factors in the Development of the BAP

The confidence that led to the establishment of the BAP, in a manner that consciously or unconsciously bypassed the recognised centres of psychiatric and neuroscientific research, is striking. One reason was perhaps the immigration into the UK, between the Wars, of scientists of Jewish and Middle European origins. As in dynamic psychiatry, such scientists have played a major role in the development of psychopharmacology. Many of the best known names in US psychopharmacology, for instance, have been Jewish – Kety, Axelrod, Snyder and Brodie. Four of the ten Presidents of the BAP have been Jewish, as well as a great number of the better known British pioneers, Quastel, Blaschko, Feldberg and Steinberg. During this period, there was a complementary decline in the world status of German-speaking countries in psychiatric research, which has not been accounted for other than by the loss of so much talent.

Another factor has been the role that English has acquired as the international scientific language, which occurred at the same time as psychopharmacology began to develop. This process was perhaps fostered by the more rapid development of the scientific media in English-speaking countries than elsewhere. A notable player in this regard was Robert Maxwell, who established Pergamon Press, which published a great number of the better known psychopharmacology journals, including the *Journal of Neurochemistry* edited by Richter, *Neuropsychopharmacology*, founded by Brodie and later co-edited by Bradley and the *Journal of Psychiatric Research*, founded by Kety and later co-edited by Sandler. Subsequently,

in the 1980s, members of BAP were involved in the establishment of a number of psychopharmacology journals – *Human Psychopharmacology*, *Journal of Psychopharmacology*, and *International Clinical Psychopharmacology*, all of which look likely to survive and in so doing, to inhibit entry to the market of journals from elsewhere. The availability of so many journals and contact with the editors of those journals must necessarily lead to increases in publications from British scientists, and scientific confidence among younger researchers.

A further factor was the desire of the British government to establish a strong pharmaceutical sector within the UK. This was done through a pharmaceutical price regulation scheme (PPRS), whereby pharmaceutical companies are entitled to a considerable amount of tax-free profits, proportional to research and development work done within the UK. The origins of this scheme date back to 1957, when a voluntary price regulation scheme was first put in place; this became the PPRS in 1987. The amounts of profit a company is entitled to are subject to five-yearly negotiation (CSA, 1993a, 1993b). This scheme has both kept drug costs in the UK low, compared with the European mean, and also, in securing a framework for investment for the pharmaceutical industry, led to the creation of a strong pharmaceutical sector, which may have contributed to the decision to locate the European pharmaceutical regulatory agency in the UK. The presence of a strong pharmaceutical company presence in the UK and the growing research departments within the leading companies, which have attracted some of the most notable British neuroscientists, has added to the critical mass of scientists working in psychopharmacology in the UK outside traditional centres (see Swann, 1987 for a consideration of the importance of this issue).

In more recent years, a number of forces, whose future effects may militate against the further development of psychopharmacology, have become apparent. One of these was brought to a focus by another government initiative, the Selected List Scheme, which came into being in 1984 (MeReC, 1993). This has generated considerable controversy and may potentially affect companies' willingness to invest in CNS research in the United Kingdom (see Hubber, 1993; Idzikowski, 1994). The Scheme was very directly influenced by the benzodiazepine controversies that became a public issue – in the UK more than anywhere else – during the 1980s. It is possible that this and other recent controversies, such as that involving halcion, are influenced by the politics of the European Community.

The origins of the Selected List Scheme can be traced back to a process of increasing media and legal involvement in health, which began in the late 1970s. In the UK, one of the earliest foci for this involvement centred on the question of benzodiazepine dependence, which has been chronicled by Bury & Gabe (1991; Gabe and Bury 1991). (This process has since developed to encompass AIDS, ME, fertility treatments and other issues). There is at present a radical disjunction between public perceptions of risk and the public's understanding of probabilities, such that remote possibilities are all too likely to be perceived as acute risks (Garattini & Healy, 1996), and as a consequence this creation of media events out of health controversies risks producing exaggerated responses from the public. There would appear to be a need for psychopharmacology to take cognisance of this and seek to inform public culture. But in the face of this need, one of its constitutional

aims, the BAP appears politically weak. Perhaps owing to the nature of the organisation with its range of constituencies, unlike, for example, the Royal College of Psychiatrists, it does not appear at present to have the capacity to act decisively on a broader front.

Psychopharmacology & Scientific Paradigms

There are many different views of how science operates. The classical hypothetico-deductive view has dominated the history and philosophy of science for the greater part of the scientific era. More recently, attention has been trained on the role of a turn toward probability in the creation of what is distinctive in 20th-century science (Kruger et al, 1987a,b). There is a further model, which predicates the advance of science on the development of effective technologies (Healy, 1990b). In practice, all sciences mix classical, probabilistic, and technical approaches to some extent – the different colours of each science depending on the mix of primary ingredients.

Psychopharmacology, along with biochemistry, is an example of a science that has been led by technical developments, whether these be the creation of instruments (such as the spectrophotofluorimeter), that have permitted the sensitive detection of neurochemicals in the brain and fluctuations in the number of receptors, or the creation of the drugs themselves, which have permitted an ever more sophisticated dissection of the human psyche (Axelrod and Healy 1996). The development of PET and MRI scanning and techniques to measure receptor occupancy in living brains engaged in various tasks, indicates that the phase of being led by technical developments is not something that belongs to psychopharmacology's past, but rather is likely to continue for the foreseeable future. Most sciences have had mechanical technologies, but whereas in physics such machines are built to detect already predicted particles, in psychopharmacology observations tumble out of the machinery faster than the theoretical superstructure can accommodate them.

In contrast to conceptions derived from physics – that science proceeds by conjecturing and refuting – developments in psychopharmacology have been serendipitous or have followed from observations thrown up by technical developments. Coppen, for instance, comparing psychopharmacology to the exploration for oil, notes that despite advances in geology, the best way to discover oil still lies in sinking oil-wells, and suggests that psychopharmacology will desert drilling in favour of theory at its peril (Coppen & Healy, 1996).

This discussion of models of scientific development appears to be of some relevance to any account of what has happened in British psychopharmacology and is likely to happen. While all the participants to the disputes surrounding the establishment of the BAP may have held the same models of science in principle, in practice they have been operating different models. When these models meet, as they are wont to do when clinicians, applied scientists, or neurochemists on the one side work with scientists who are following classical research programmes such as physiologists, behavioural biologists, and experimental psychologists on the other, there has been incomprehension and even hostility.

There is potential hostility every time scientists taking a 'technical' approach

('I've just developed a new technique/marker, wouldn't it be interesting to see what it does?') apply for support from grant-giving bodies, which tend to be dominated by scientists taking classical approaches to science. Tensions have occurred when the question of honorary membership of the BAP has been raised. The proposers of those who have discovered phenomena rather than elaborated theoretical positions have had to work harder to justify their proposal. There has recently been considerable tension concerning proposals for presidency of the BAP, predicated at least in part on the apparently greater weight put on classical rather than applied scientific achievements. These conflicts have often involved a classical centre (Oxford/Cambridge/Maudsley) versus the 'periphery'. Thus, the politics of an organisation like the BAP may reflect a clash between models of science.

The resulting tensions are set within a set of larger developments, such as the turn in government policy which dictates that funding for big projects should be routed to centres such as Oxford and Cambridge. While the centre would therefore seem liable to capture the credit for advances made on the periphery, the logic of drug development, which is the primary driving force in psychopharmacology, will always tend to subvert this. The genetic code may be determined in Oxford, Cambridge, Yale, and Harvard but the proteins that result from such advances will be owned by pharmaceutical companies. The market development programmes for the products that may result are quite capable of contributing to extensive revisions of nosological frameworks, as the development of DSM-III and industry support for studies in OCD, panic disorder, and social phobia illustrate.

The role of the pharmaceutical industry in drug development also throws a light on Thomas Kuhn's arguments regarding the existence of normal and revolutionary science. Kuhn postulates that normal science is what the vast majority of scientists spend their time doing. In the case of psychopharmacology, one motive for scientists to spend time assiduously at normal science is that the pharmaceutical industry is inherently conservative. This, indeed, may be increasingly so because the processes of bringing a drug to the market place takes ever larger amounts of money, which means that only 'concepts' for which the profit margins are well established can survive. The financial exigencies introduce into any consideration of the history of psychopharmacology the issue of a struggle for survival among the concepts of that science. Richards (1987) has argued that this is true for all scientific concepts, but it is difficult to think of another science in which the dynamic is so clear.

This consideration raises questions regarding the most appropriate framework in which to consider the history of psychopharmacology. Just as there is a divide between classical and technical models of scientific development, so also there is divide between classical historiography, which is happier tracing the lineage of ideas, and the less glamorous historiography of commodities. Many psychotropic drugs have, however, intricate developmental histories that cannot be explained by any appeal to a history of ideas, but rather owe a great deal to efforts to create markets and the vagaries of those markets (Swazey, 1974). Following their launch, drugs become cultural events owing in part to the efforts of companies to create brand name loyalty (Mann & Plummer, 1991). The history of psychopharmacology would appear to offer opportunities for this kind of history (see Beaumont & Healy, 1993), but to date, there has been

little apart from Josephine Swazey's review of chlorpromazine (Swazey, 1974). The recent emergence of Prozac as a media event serves to emphasise the possibilities inherent in this approach.

The Prozac story comes at a time when medical issues are increasingly becoming front-page news and a central focus of political concern, by virtue of the philosophical and moral implications of developments in genetics, reproductive technology, and behavioural change brought about by psychotropic compounds. The ability to intervene effectively in human behaviour in this way has brought closer a fulfillment of the agenda set by Julien Offray De La Mettrie in the 1750s to make medicine the philosophy of the masses (Welman, 1991). For La Mettrie, philosophising was empty, unless it led to an ability to intervene effectively in human behaviour. He believed that advances in medical science would lead to this possibility in due course and that ivory tower philosophising would vanish, at that point. Seen from this perspective, the cultural event that is Prozac has considerable historical resonance.

Prozac and the other 5HT reuptake inhibitors are also compounds that are safe enough to make it realistic for companies to consider selling them over the counter (OTC). In the course of 1994, a range of H-2 antagonists, antiviral agents, steroid creams, and inhalers have changed status from prescription-only to OTC, largely in an effort to circumvent health care reforms; what odds on the 5HT reuptake inhibitors following suit? If this happens, market development strategies will clearly change in response, probably leading back to more dimensional views of mental illness. In retrospect, the years between 1974 and the mid-1990s may prove to have been a particularly interesting historical period during which a conjunction of the interests of certain medical prescribers and the ethical pharmaceutical industry had distinctive effects on the theory and practice of psychiatry.

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5 After Shell-Shock: Aspects of Hysteria since 1922

HAROLD MERSKEY

The history of 'Shell shock' demonstrates that war has contributed profoundly to our appreciation of the nature of psychological complaints (Merskey, 1991). Once it was recognised that the shell-shock of 1915 was battle neurosis, fright, or even malingering, the scene was set for doctors to treat many physical complaints and some psychological ones as 'functional' or hysterical. The approach had been popular enough for generations, but a handy theory was now available which had gradually evolved from the observation that thoughts could cause symptoms (Reynolds, 1869; Wright, 1980) into the notion that emotional conflict could produce symptoms which were a way of accommodating to the patient's fear of his (or her) dangers – both conscious and unconscious (Breuer & Freud, 1893-1895). This notion, both powerful and subtle, could be made use of, with or without the Freudian belief in infantile sexuality. It became – and remains – the dominant hypothesis for the psychogenesis of hysterical symptoms. Following World War I, the contemporary discussions and conclusions about shell-shock were drawn together by a commission at the War Office (Report, 1922). Thereafter only negligible discussion of the subject occurred, but the notion of hysteria in response to stress was established. In this chapter, I explore the changes in some of the themes which, for the subsequent half century, have been encompassed under the term 'hysteria', especially the relationship to stress, physical complaints, and dissociative phenomena.

Post-Traumatic Stress Disorder

The First World War left the participating countries with numerous disabled veterans: in Britain, as many as 65,000 former soldiers were receiving pensions for neurasthenia and allied conditions in 1921 (MacPherson *et al*, 1923). A veteran injured in his mind was as much a feature of the scene as the amputee. When the Second World War began, the lessons of the First, which to some extent had been put aside, were again recognised and quickly applied: the removal of affected individuals from the firing line and the quick treatment of psychiatric casualties reduced the impact of stress (Grinker & Spiegel, 1945; Sargant & Shorvon, 1945). Some have held that selection processes reduced the impact, in terms of numbers of soldiers affected, because the most vulnerable were

kept out of the firing line, but Chalke (1954) has expressed doubts about this view. In any case, in the Second World War, it was widely understood that psychiatric illnesses were once again produced by stress, and that the extent of exposure to danger carried a risk of anxiety and other symptoms almost *pari passu*.

Later, awareness gradually emerged of the prolonged effects of psychological stress in American soldiers returning from Vietnam. The common phenomena included depression, an explosive aggressive reaction, sleep disturbance with nightmares, startle responses, discomfort at stimuli associated with previous life-threatening experiences, constriction of ego interests and adaptive functions, and an associative reaction, i.e. 'flash-backs' (Haley, 1978). An enormous literature has developed on illnesses induced by catastrophic stress, including reports from many countries and campaigns from Afghanistan to Vietnam, as well as on the sufferings of concentration camp survivors and prisoners of war in Japan and the USSR; the effects of torture in a wide range of countries; and the misfortunes of civilian survivors of catastrophes in Australia, Britain, United States, and elsewhere (Choy & DeBosset, 1992; Wilson & Raphael, 1993). In the United States, Congress mandated a National Center for Post-Traumatic Stress Disorder (PTSD) in 1984 which carries out a broad range of multi-disciplinary activities in research, education, and training, including the publication of a PTSD research quarterly since 1990.

Making this diagnosis has been assisted or even promoted by the criteria for PTSD which were included in DSM-III (1980) and DSM-III-R (1987). Its existence enables patients and their illnesses to be better discriminated, since PTSD does not require hysterical symptoms for its diagnosis, nor do hysterical symptoms require the presence of anxiety in order for the diagnosis to be made. One of the other effects of this category may have been to reduce the frequency with which diagnoses of conversion symptoms or dissociative disorders were made, at least in those who have experienced overt public stress such as battles or catastrophes affecting large numbers. Hysterical symptoms are, however, reported much less frequently now from the same quarters which report PTSD and it seems likely that if – as is the case – there is some knowledge of the symptoms of PTSD among patients who might otherwise develop overt conversion symptoms, the former would be preferred. At least informally, psychiatrists are beginning to raise the possibility that some of the reports of PTSD are either artifactual, or due to selective emphasis. In particular, as with any other diagnosis which depends upon subjective phenomena, the symptoms of PTSD may be adopted for purposes of hysteria or malingering. In consequence, Pitman and Orr (1993) have offered a laboratory procedure to corroborate the report of PTSD by measuring physiological responses during the planned recall of stressful events.

The problem has been complicated by the development of civilian symptoms such as Multiple Personality Disorder where there is reason to believe that the diagnosis is produced by suggestion and simulation and through encouragement from both medical and lay sources (Kenny, 1986; Fahy, 1988; Aldridge-Morris, 1989; Merskey, 1992a). In this case, it is now regularly claimed that true MPD sufferers have always been victims of childhood abuse (Coons & Milstein, 1986; Putnam et al, 1986; Schultz et al, 1989), and MPD is then represented as a post-traumatic syndrome. The great majority of cases and publications on this

topic are found in the United States, while for the most part the systematic critical analyses have appeared in Britain.

Other individuals who have suffered from sexual abuse in childhood may be alleged to have an incest survivor syndrome (Herman, 1993). Herman et al (1986) find that survivors who have experienced forceful or repeated, prolonged abuse or severe physical violation develop persistent difficulties in their adult lives. They argue that violent, prolonged, or intrusive abuse, or abuse by a primary caretaker, represent stressors that are beyond the adaptive capacities of all but the most exceptional children, and will regularly produce a long-lasting traumatic syndrome.

It is now recognised that the frequency of abuse in childhood is unquestionably high, whereas formerly it was much neglected. The likelihood that some cases of reported abuse are artifactual has emerged with the recognition that many individuals in psychotherapy in the United States and Canada have been encouraged falsely to recall supposed experiences which they had totally forgotten (Wakefield & Underwager, 1992; Loftus, 1993). In Britain, the Cleveland cases provided an example of allegations of the current abuse of children which were proven to be mistaken.

Despite such aberrations, the recognition of PTSD in a wide variety of survivors and places has brought forth efforts to treat civilian survivors as well as veterans. Denmark (Somnier & Genevke, 1986) Canada (Allodi & Cowgill, 1982) and Australia (Silove et al, 1991) have pioneered such work for victims of torture.

Psychotherapy

One of the effects of the treatment of shell-shock and post-traumatic stress disorder was to establish the professional identity of many psychiatrists as psychotherapists (Merskey, 1991). Psychological techniques of treatment were thoroughly evident in the Nineteenth Century. Their use in the management of patients by physicians can be seen readily in historical studies, e.g. Hirschmuller (1989), Oppenheim (1991), and Shorter (1992). The individual relationship between the doctor and different patients and its effect is evident repeatedly and of course, systems of treatment whether described as 'moral', or as related to suggestion, abounded (Tuke, 1892). Stone (1985) suggested that the Clinics of the Ministry of Pensions led to the development of reforms and innovations in psychiatry in Britain after World War I. Although psychotherapy was not a new phenomenon in 1914, it is probable that these alternative clinics provided a definite impetus for work outside psychiatric hospitals. Psychodynamic notions, originally derived from the analysis of hysterical symptoms, spread the importance of transference in the therapeutic relationship, and the patterns of treatment described for patients with supposed hysterical symptoms sometimes took the relationship with the patient into account. This applied throughout the period between the wars and also following the Second World War. A fairly typical description of the treatment of hysteria (Henderson and Gillespie 1950) emphasises that the principles advocated for the treatment of anxiety states also applied to the treatment of 'hysterics': a complete physical examination and a careful chronologically detailed history were essential. Following that, Henderson indicates various measures which might be used, including ordinary conversation, suggestion, free association, and hypnosis.

'The object of all these methods is to bring back to consciousness, against more or less 'resistance' on the patient's part, the mental events which have been associated with the development of symptoms'. He mentions the possible emergence of transference, and the occasional need for strongly imperative behaviour such as forcible movements of limbs by the physician, even against resistance.

The treatment of patients with hysterical symptoms was often not gentle. Yealland (1918), treating soldiers, used vigorous electrical stimulation, which today would hardly be countenanced as either ethical or acceptable, to encourage patients to recover their capabilities. After the war Wagner-Jauregg, a professor of psychiatry in Vienna who later received the Nobel prize for his malarial treatment of general paralysis, was accused at a commission, of which he was initially a member, of having countenanced the cruel and abusive treatment with electricity which his assistant Dr. Michael Kozlowski administered to a soldier with war neurosis. Freud gave evidence in his defence and Wagner-Jauregg was exonerated (Eissler, 1986). Not only were similar cruel treatments probably applied in all the combatant countries, but as Babington (1983) indicated, soldiers were liable to execution if they were not considered to be ill. There was thus always a tendency to see the war neurotic as in some way escaping his duty.

The extent to which this view was held varied from doctor to doctor. However, by the 1920s, neurological methods for the diagnosis of hysteria were well regarded, and relied upon physical discrepancies in responses which suggested to the physician that the patient was consciously or unconsciously refusing to do something of which he was in some way capable (e.g. Hurst, 1940). Hysterical symptoms were often thought of in some measure as counterfeit or bad behaviour. For example, a patient with epilepsy in the 1970s who was found to have hysterical fits as well said: 'I wanted them to attend to my real fits so I had some fake fits and when they found out about my fake fits, they sent me to a mental hospital'. Rejection and attitudes of superiority were never far from the thoughts of many physicians dealing with supposed hysterical complaints. The neurologist was at particular risk of developing these ideas because he most often carried the responsibility of determining whether or not the physical complaints were 'genuine'. Henry Miller (1961) popularised Kennedy's line that 'Compensation neurosis is a state of mind, born out of fear, kept alive by avarice, stimulated by lawyers, and cured by a verdict' (Kennedy, 1946). After too long an interval, Mendelson (1982) resoundingly trounced this comment, pointing out that in ten studies undertaken since the Second World War, none had confirmed Miller.

During the first and second World Wars, neurologists were often in a sense the guardians of the public interest, preventing the undue development of claims for recompense or advantages as a result of physical illness, while psychiatrists had the easier role – and harder task – of curing the more intractable cases. The attitudes of neurologists were being based upon questions of war-time risk or civilian financial compensation, and were therefore frequently sceptical. In the United States, it took a classic paper by Strauss and Savitsky (1934) to demonstrate that many individuals were being denied compensation on the grounds that they did not have physical illness, when indeed they had overt proof of neurological damage such as extensor plantar responses.

An atmosphere of hostility or contempt towards the patient with hysteria permeated much of the treatment, although there was also an approach

based upon sympathy, the elucidation of problems, and emotional support. Henderson's textbook describes the need for practical measures in any event.

Mayer-Gross et al (1954) observed 'In practice the hysteric is not infrequently a malingerer too'; and held that all clinical psychiatrists agreed on a close connection between hysterical symptoms and a related structure of personality, although the latter was not obligatory. This personality was not impressive. The traits associated with hysterical symptom were summarised as affective immaturity and affective instability. The authors compared the hysterical patient to a child, and offered a number of uncomplimentary descriptions e.g. 'Quick but effervescent enthusiasms, infatuations, easy laughter and tears . . . underneath .. no depth to the emotion . . . egocentric. The whole external world is only seen in the light of how it affects him; a clear grasp is maintained of his own rights and the obligations of others towards him, but his own duties are forgotten. In affection, the hysteric is *possessive* . . . Everything is valued in superlatives and motivation is impossible . . . Being himself immune from any serious disturbance by deep emotions, the hysteric feels at home in the stormiest situations . . . ' These traits were linked to an incapacity for insight.

Merskey and Tonge (1965), more softly spoken, also reveal the doctor's ambivalence with patients of this type. 'Self deception . . . comes more easily to these people than to others. It never fails to surprise that after a stormy interview with much shedding of tears - and having to borrow the doctor's handkerchief! - a hysteric will rise, repair her make-up and sail brightly out of the consulting room . . . Certainly it is true that much less has happened underneath than might be thought from the surface display of emotion'. The collection of traits and the pattern of this description indicate some feelings of difficulty in dealing with this type of patient.

These problems have pervaded the management of patients with conversion and dissociative symptoms, and continue to exist. They may have become slightly less difficult with the increasing recognition that many patients with hysteria have an important organic component underlying their symptoms. More will be said about this later, but even psychiatrists commonly find it easier to sympathise with patients who have an overt physical illness, or a severe psychosis which can be clearly characterised as illness, e.g. schizophrenia or mania, than with patients who have typical conversion or dissociative symptoms.

However, by the end of the second World War, the recognized frequency of hysterical symptoms had begun to decline and attitudes to their psychotherapy changed accordingly. Abse (1966) described the reduction in numbers of classical hysterical complaints such as paralysis and blindness, and the development in their place of headache and pain complaints in soldiers under stress. This was particularly true of sophisticated populations and there is widespread agreement that in the developed world, hysterical symptoms have become quite rare except in certain centres such as neurological or military psychiatric units. Even in the latter, hysterical symptoms are much less frequent than they once were (Merskey, 1979).

Organic Brain Disease

Hysterical symptoms were long recognised as accompaniments of general and local diseases (Gowers, 1893). Kraepelin (1904) noted that hysteria was not rare

with epilepsy. Guttman (1932) cited numerous authors who had recognised the simultaneous occurrence of organic brain disease and hysterical symptoms. Schilder (1935) went on to develop the concept of 'Organic Repression'. He went so far as to say 'When I use the term "organic repression" I wish to emphasise that we are concerned with a phenomenon, which on a structural level, repeats what is going on in other repressions in the so-called psychic level'. This is difficult to follow, but it suggests that the same symptom might result from either an organic illness or a psychological disturbance. Schilder thought that anosognosia, a tendency to affect some part, usually one-half, of the body might be such a symptom. He also suggested that neuroses following head and brain injuries might be due to a change in the function of the brain as a result of cerebral organic syndromes. These could provoke neurotic attitudes (Schilder, 1940).

Comments such as these suggest four main conclusions. First, organic illness might produce an effect amounting to the repression of a conflict. Second, the same symptoms can have either an organic or a psychological cause. Third, organic disturbances of brain function can provoke neurotic attitudes, and last, organic disease and hysterical symptoms frequently co-exist. The first of these lines of argument is conceptually difficult and has not proved popular. The others can all be supported from a case report by Lewis (1953). A British soldier in the First World War suffered from a confusional state due to neurosyphilis and then contracted malaria. Some 17 years later, he was described as a classical case of dissociative memory disturbance in a book entitled *'Persons One and Three - A study in Multiple Personality'*. (Franz, 1933). On re-admission to the Maudsley Hospital London (before the book had appeared), he had a positive serology for general paralysis and after treatment with induced malaria, still showed some organic memory disturbance. It seems likely that this patient had a memory disturbance to which both organic and psychological causes contributed and in which organic and psychological patterns appeared. There is a distinct possibility that both types of memory disturbance could have been related to the presence of a defect due to organic disease.

The foregoing straws in the wind, among others, kept clinicians wary of the possibility that organic disease may underly apparently pure hysterical symptoms. However, the view of this topic changed dramatically, with the Shorvon Lecture given by Eliot Slater, the Senior Physician in Psychological Medicine at the National Hospital for Nervous Diseases, Queen Square, in front of an audience containing a substantial number of his neurological colleagues. Slater had conducted a nine-year follow-up of 85 patients drawn from an initial sample of 112 whom he had seen at the National Hospital. Four of these 85 patients had died from suicide and 8 from organic disease; 24 were originally considered to have organic disease, and 22 were later found to have organic disease which might have been relevant. A further 33 had no organic pathology, but 2 developed schizophrenia, and 8 had affective illness. Finally, there was a nuclear group of only 7 young patients with classical conversion symptoms in response to stress, and 14 with chronic personality disorder and multiple symptoms. Slater indicated very strongly that he thought the diagnosis was poor in many of these cases, and that neurologists and psychiatrists, himself among them, had failed badly in their appraisal of the patients. He suggested that the diagnosis of hysteria was 'a delusion and a snare',

but remained willing to use the word hysteria as an adjective, although not as a noun.

When his speech appeared in the *British Medical Journal* (Slater, 1965), it provoked a polemical response, including ad hominem remarks by Sir Francis Walshe (1965). However, subsequent reports (Whitlock, 1967; Merskey & Buhrich, 1975) confirmed Slater's observations, although a series by Lewis (1975) from the Maudsley only found 4% of subjects with organic disease, and Roy (1982) has argued that hysteria is not specially attributable to organic brain disease. When hysterical symptoms occur, an organic disease has to be seriously considered. On the other hand, such symptoms remain fairly common in less developed countries (Hafeiz, 1980).

Hysteria has often been diagnosed because the absence of organic disease is taken to justify a psychiatric diagnosis. Among the syndromes which have been misdiagnosed as a result are hemifacial spasm, facial dyskinesia, and dystonia, spasmodic torticollis, and painful legs and moving toes, brain tumour, ectopia cerebelli, muscular dystrophy, chronic paroxysmal hemicrania, cluster headache, and temporal lobe epilepsy (Merskey, 1985). When L-dopa came into use for Parkinson's disease in the 1970s, there was a radical change in thinking. It soon became apparent that the abnormal movements of dyskinesia and dystonia were readily provoked in patients with Parkinson's disease when their dose of L-dopa became too high, and were removed by reducing the dose. Henceforward, dyskinesia, dystonia, and spasmodic torticollis ceased to be primary psychiatric illnesses. Dystonia had already had a push away from hysteria as a result of experience with neuroleptic drugs, after chlorpromazine was introduced in the 1950s.

Gould et al (1986), emphatically reinforced this new thinking. These authors carried out systematic examinations for seven of the supposed signs of hysteria. These included a history suggestive of hypochondriasis, potential secondary gain, belle indifference, non-anatomic or patchy sensory loss, changing boundaries of algesia, sensory loss (to pinprick or vibratory stimulation) which stopped at the mid-line and give-way weakness. They looked for these features in 30 patients with acute damage to the nervous system, usually stroke. All the patients had at least one of the signs. The mean number per patient was 3.4. The authors concluded that hysteria is easily misdiagnosed if the above signs are accepted as pathognomonic, and that the tests lack validity. Reasons why some of these sensory signs are misleading have been put forward and are discussed below in connection with changes in our understanding of pain.

Changes in Pain and Hypochondriasis

Historically, pains have always had a prominent place in the diagnosis of hysteria. Sydenham (1697), Whytt (1761), Briquet (1859), Charcot (1889), Gowers (1893), and Savill (1909) all expected pains to be hysterical. The statement of Brodie (1837) that 'In upper class women' four-fifths of joint pains were hysterical is often quoted. Breuer & Freud (1893-95) adopted this view particularly for pain in the face. Throughout the Nineteenth and Twentieth Centuries, it has hardly been disputed that pain may be an hysterical symptom. Some authors, e.g. Anstie (1871) believed that neuralgias, that is to say organic

pains, were an ultimate consequence of emotional disturbance including even 'unconscious resentment of the neglect of sexual functions'. Even lately, hysteria has been regarded as a common cause of chronic pain in psychiatric patients (Merskey, 1965a). One of the most influential papers in this respect (Engel, 1959) described chronic pain as the self-punishing, masochistic, and hysterical solution to problems of adaptation. Thus, pain has taken the place of hysteria in many formulations and offers the same idea of a symptom which is due to motivation or reinforcement.

Cohen et al (1953) followed by Perley and Guze (1962) and Guze and other colleagues produced a series of publications giving a particular definition of hysteria. In the first instance, the patient had to demonstrate a dramatic and complicated medical history beginning before age 35, and secondly the patient had to admit to 25 symptoms in nine out of ten special groups of symptoms. Thirdly, no other diagnosis could be made for these symptoms. This initial formulation was at first called Briquet syndrome (Guze, 1967) and later somatization disorder, a term adopted in DSM-III and DSM-III[R] with some modifications. This condition relies heavily upon pain as a hysterical symptom. It is said to occur in as many as one in 100 'normal' postpartum women (Farley et al, 1968) and in 10% of psychiatric in-patients in university hospitals (Bibb & Guze, 1972). A number of the publications by Guze and his colleagues appeared first in the *British Journal of Psychiatry*, because of resistance to their approach in the U.S.A. Some have thought these figures unduly high. In population studies of the DSM-III diagnosis of somatization disorder, a rate of 0 – 0.7% was found (Escobar et al, 1987; Swartz et al, 1986 & 1988) and Kirmayer and Robbins (1991) observed an incidence of 1% for DSM-III-R somatization disorder in 685 patients attending two family medicine clinics. Since somatization disorder probably represents one end of a continuum of symptoms, from the most severe down to normal or average responses, defining it as a syndrome may be a classification by severity rather than by pattern. This has unquestionably been popular for research purposes, however, and many studies of somatization disorder, its frequency and associations have appeared in the literature of the 1980s and 1990s. At the very least, these studies give some idea of the burden of medical care required for patients with such complaints.

It is desirable to make some distinctions between somatization disorder and hypochondriasis. Hypochondriasis has many meanings; Kenyon (1965) lists 18 different usages of the terms hypochondria and hypochondriasis. The mildest form is concern over symptoms like palpitations or headaches, which may be due to anxiety and respond readily to medical examination and reassurance. More persistent hypochondriasis is associated with severe illnesses ranging traditionally from melancholia to delusional illnesses and states of dementia. The distinction from hysteria may be difficult but – at least in theory – hysterical patients may be more pleased with their symptom than hypochondriacal ones. Gillespie (1929) summarised the criteria for regarding a condition as essentially hypochondriacal. They included preoccupation 'with a real or supposititious physical or mental disorder; a discrepancy between the degree of pre-occupation and the grounds for it . . . and an affective condition best characterised as interest with conviction and consequent concern, and . . . irresponsiveness to persuasion' (p. 45). Henne (1955) distinguished between simple hypochondria and delusional hypochondria and made subordinate characterisations of the different groups.

The advance which deserves to be singled out, however, was Pilowsky's (1967) systematic study which led to the observation that hypochondriasis (at least in the more marked cases) was characterised by both disease phobia and disease conviction, i.e. the patients feared they were at risk of having illness and at the same time believed that they had got it.

Lipowski (1968) favoured the use of the term 'somatization' to cover the production of bodily symptoms from psychological causes. He defined this as the 'Tendency to experience conceptualize and/or communicate psychological states or contents as bodily sensations, functional changes, or somatic metaphors'. Besides its use with respect to somatization disorder, the word somatization has been employed for the presentation of physical symptoms on a psychological basis affecting much larger numbers of individuals. Von Korff et al (1988) and Dworkin et al (1990) have found widespread evidence of somatic complaints in individuals with chronic pain (although some of this may have been physically founded). Lipowski specified that the term was to include several categories of symptoms. Thus in practice, patients may have physical symptoms because of anxiety which produced physiological changes, or because the symptom is being used to solve a conflict, as in classical conversion hysteria, or because they have somatization disorder, or because they are hypochondriacal. In the case of hypochondriasis, the mechanism by which the symptom develops may vary. It may be related to the presence of a major psychosis such as schizophrenia or severe depressive illness, or it may be pure hypochondriasis in which the patient is fearful of having this symptom and convinced that he has it (Pilowsky, 1967). It may also reflect the presence of a minor physical symptom to which increased attention is given because of a variety of psychological problems, and which resolves with the treatment of the psychological problems.

Kirmayer and Robbins (1991) demonstrated that three forms of somatization affected 26.3% of patients in family practice. These were characterised by high levels of functional somatic distress (resembling somatization disorder), hypochondriasis, or somatic symptoms as the exclusive presentation of depression or anxiety. They observed that the groups had different sociodemographic features and illness behaviour and emphasise the importance of maintaining the distinction between the different types of somatization. Like hysteria, somatization has many subdivisions in meaning. It is hard to support the continued use of the expression.

Within the field of studies of chronic pain, psychodynamic hypotheses arose against a background of psychoanalytic theories of the 30s and 40s, ranging from topics connected with phantom pain to pain in almost any part of the body (Merskey & Spear, 1967). More than 30 authors had described plausible relationships between pain, guilt, and hostility, but the evidence was essentially anecdotal. Only a few reported more than a dozen or so cases and none of them considered whether guilt, resentment, and hostility, transformations of libido which were frequently mentioned, could occur similarly without pain being present. Szasz (1957) proposed a modification of the basic analytical model of psychological experience containing four systems – id, ego, super-ego, and external reality. He believed that the place of the body in the traditional scheme was very ill-defined and suggested that it should be perceived by the ego as an object. Pain would then arise as a consequence of a threat of loss or damage to the body, in the same way as anxiety arises from threatened loss of an external

object. The question whether the symptom was considered organic or functional depended upon the observer's assessment of the reality of the threat to the body. Szasz's contribution is perhaps less important with respect to his particular hypothesis than in the emphasis placed on understanding pain as a psychological phenomenon, whatever its aetiology.

Engel (1951, 1959), whose importance has been mentioned above, provided a notable systematic discussion, with impressive clinical case histories. He emphasised the occurrence of various individual characteristics of the 'Pain prone patient' prior to the onset of pain, and said that although we might be inclined to pass this off as a consequence of pain, such a view was mistaken since his patients often tended to put themselves in the way of their misfortunes. He did not offer statistical proof of his ideas, and later studies have only provided limited or weak support. Spear (1966) compared random samples of psychiatric patients with pain and without pain. He found no evidence to establish a relationship between clinically significant pain and hostility, even when the data were interpreted as liberally as possible. Merskey (1965 a & b) studied patients with persistent pain who were much more akin to those of Engel. He found increased resentment, poor sexual adjustment, increased frequency of operation, lower intelligence and social class, and a family history of painful conditions in patients with pain, compared with those not in pain. These findings were all in accord with Engel's suggestions, but related to a psychiatric population in whom physical illness had been excluded. The dynamic hypotheses of increased hostility or aggression and self-punishing behaviour were not more evident in these patients than in other psychiatric patients. A more detailed attempt to explore these hypotheses by Adler et al (1989) fails to provide adequate support for Engel's theories, although the authors think they have done so, largely because of a failure to control for the most appropriate comparison group. Thus, this fundamental idea, which has been at the heart of much discussion of psychosomatic illness for the last 20 or 30 years, has gained only some limited support and is essentially unconfirmed in its principal thrust.

Other information which began to be influential in the 1970s led to a substantial reduction of the emphasis on pain as an hysterical symptom. Part of the trend resulted from the gradual decline of the view in psychosomatic medicine that psychodynamic hypotheses at large would explain physical complaints (Lipowski, 1968). It is no longer supposed that psychological mechanisms are largely or wholly responsible for such disorders as multiple sclerosis, Crohn's disease, and asthma, and physical treatments have become more effective in some of these conditions, which had often been treated as though they were of psychological origin. It also became evident that much of the increase in emotional disorder in patients with chronic pain, was likely to result from the consequences of pain, unemployment, loss of self-esteem, and other effects of distressing disabilities (Woodforde & Merskey, 1972; Merskey, 1974; Sternbach, 1974). This obvious common sense had been somewhat neglected until the early 1970s. In addition, it was increasingly recognised that the samples seen at hospital clinics were subject to selection (Merskey, 1974). Still other conditions which had been treated as hysterical, or largely due to the desire for compensation, were increasingly recognised as organic in aetiology. For example, the cervical sprain injury (whiplash) which had previously been treated as a psychological problem if the complaints lasted for more than a few weeks, was increasingly

recognised as a cause of persistent physical illness (Macnab 1964 & 1973; Merskey, 1984; Deans, 1986; Watkinson et al, 1991). Gould et al (1986) introduced further evidence on the unreliability of hysteria which was cited above. Simultaneously, very important neurophysiological information was also becoming available, which had a direct bearing on the sensory aspects of hysteria.

Wall (1984) and his colleagues were steadily investigating the effects of plasticity in the nervous system with particular reference to the receptive fields of afferent neurones in the dorsal horn. They showed that these receptive fields could change and extend. Thus in the rat, three to four days after deafferentation, cells which formerly responded to stimulation within the usual anatomical area would begin to respond to stimuli from other areas. McMahon & Wall (1984) showed that cells in lamina I of the dorsal horn would extend their receptive fields slowly after about ten to fifteen minutes to include a burned area in an adjacent field. Likewise, Cook et al (1987) showed that no more than twenty electrical conditioning stimuli supplied at a frequency of one per second to C-fibre afferents from the gastrocnemius muscle of the rat would more than triple the receptive field of a cutaneous afferent neurone, whether that neurone responded previously to a firm mechanical stimulus or to pinch. Moreover, neurones that originally responded only to pinch would begin to respond to touch about fifteen minutes after the stimulation. This demonstrated, very elegantly, that *regional* sensory changes could be physiological, even if they were not anatomical. This partially undermines the traditional basis for proving that a symptom is hysterical, i.e. that it does not correspond to an anatomical distribution, but rather to an idea in the mind of the patient. It became necessary now to prove more about the case than some non-anatomical findings, before it was possible to attribute the symptom to some thoughts of the patient.

Another conceptual approach to the psychogenesis of pain is based upon behaviourist theories. According to Skinner (1953), pain behaviour is mediated by operant conditioning. The ways by which pain is signalled are termed operants, and the operants are held to be controlled by the consequences which immediately follow their appearance. Subjective experiences are not included in this formulation, but only external responses including verbal statements. If an operant is systematically followed by a favourable consequence, it is said to be positively reinforced and likely to recur in response to similar stimuli. If it is not reinforced, the operant will diminish. Aversive consequences such as punishment, promote extinction of an operant. This formulation is not applied to so-called respondent pain in which there is thought to be a physical basis for pain. Fordyce (Fordyce et al. 1968 & Fordyce, 1976) developed a systematic approach to treating pain of psychological origin by methods which encourage patients to avoid showing signs of pain or complaining of it. Health professionals and family members are alike encouraged to ignore the expression of pain, thus tending to the extinction of such expressions and to reward activity which might be thought to be inhibited by pain.

This formulation covers all types of pain in which psychological factors may be considered to be important. Thus, it will refer alike to pain due to ideas which we have called hysteria, pain associated with depression, pain due to psychophysiological effects as in anxiety, and pain due to delusions. In practice, it is most often applied to pain where it is thought that a motive is relevant to its expression, or to pain associated with depression. The approach has

gained widespread influence in North America, perhaps especially because it was associated with the valid demonstration that some types of musculoskeletal pain, e.g. pain related to under-use of the musculoskeletal system, can benefit from exercise. It has been widely applied in many treatment programmes for chronic pain, although usually not in isolation (Aronoff et al. 1983). It has been criticised for inconsistency (Schmidt, 1987), for its failure to appreciate the patients' subjective experiences (Merskey, 1982, 1983a and b), and also for some problems of conflict of interest (Merskey, 1992b) in which doctors may themselves be reinforced for things which suit the patient's insurance company, rather than the patient. The relevance to hysteria is that it has provided a substantial and influential movement for the treatment of patients, some of whom may be presumed to have motivated symptoms.

Dissociation

The evolution and vicissitudes of this concept are of substantial current interest. Several controversial topics hinge upon it, particularly multiple personality disorder, the false memory syndrome, and the plausibility – or otherwise – of the whole notion of the repression of memories. Further discussion of those is offered elsewhere (Merskey, 1994). Here, to begin with, it is necessary to look at the development of the term.

It has been customary to regard hysterical symptoms which do not affect the body as dissociative. The usual psychodynamic interpretation implies that a split occurs between the symptom which remains conscious and the emotional conflict which becomes unconscious. In other words, two connected phenomena become separated and amnesia occurs for an important problem. Conversion symptoms can be considered as dissociative symptoms affecting the body. In both cases, the essential phenomena are a separation of ideas and amnesia for relevant material.

Two principal sources, Janet and Freud, are responsible for the basis of our ideas on this topic. Janet drew part of his concept of consciousness from John Stuart Mill and from Herbert Spencer's *Principles of Psychology* (Janet, 1891). Consciousness could be a field of variable size in which sensory phenomena and other experiences, including ideas, received attention. It is a universal experience that the direction of attention shifts and the items which remain in consciousness vary. For Janet, consciousness could be narrowed or 'retracted', or enlarged. The most extreme case of retraction was held to occur in the case of catatonia (Janet, 1891). In current language, we could say that he believed that the contents of consciousness fluctuated in accordance with that selective attention with which we monitor first one source of sense data and then another. Items in the visual field give way to tactile sensations or vice versa, and thoughts of our own, or comments addressed to us, enter into consideration and depart from it. The extent of the field of consciousness varies very much with individuals and their states of mind (Janet, 1907, p.307). However, complete consciousness is not solely expressed by the kaleidoscope of impressions or notions. It also involves the idea 'I see, I feel a movement,' (Janet, 1907, p.304). The ensemble includes an idea of personality or of the whole person of the individual, as well as those cognitive constituents which do not necessarily involve self-reference.

The ideas which come in to consciousness change readily, and in hysteria Janet held that the field of consciousness tended to diminish, or become narrowed, or 'retracted', while neglected sensations might become lost altogether. Thus, anaesthesia might appear in a neglected arm. The difference from normal lies in the patient's susceptibility to such retraction, or narrowing, or losses, a consequence of 'feebleness . . . of thinking' (Janet, 1907, p.311). This depended also upon abulia or a loss of will by the patient.

Dissociation then became an important element in Janet's definition of hysteria: 'Hysteria is a form of mental depression characterised by the retraction of the field of personal consciousness and a tendency to the dissociation and emancipation of the systems of ideas and functions that constitute personality' (Janet, 1907, p.332). Janet was also happy to cite Breuer & Freud (1893-1895, pp.62-63) as having a very similar opinion when they spoke of 'This division of the consciousness which has been clearly established in celebrated cases of double existence, exists in a rudimentary state in every hysterical; the disposition to this dissociation and at the same time to the formation of abnormal states of consciousness . . . constitutes the fundamental phenomenon of this neurosis'.

Although this quotation from Freud shows that he also relied upon the concept of dissociation, he takes it far more for granted, uses it at first, and then gets on with other business which is more interesting to him. He attends much more to dynamics, drives and motives. Breuer (p.312) emphasises that dissociation is related to 'an excess of efficiency, the habitual co-existence of two heterogeneous trains of ideas'. Dalbiez (1941) expresses the generally accepted view that in Janet's opinion, anomalies of psychic activity have to be explained by 'The purely negative idea of "*deficiency*"' (vol. 1, p.190). Breuer and Freud's views of hysteria differ from Janet in a number of respects: a refusal to trace hysteria directly to a congenital hereditary degeneration (Breuer, p.312); offering in place of a mere description a dynamic explanation by a play of mental forces; and referring psychical dissociation not to a congenital disability but to a special process called 'repression' (Freud p.61). Freud's system of explanation relies on the positive idea of conflict and efficient causality. Throughout the studies on hysteria, Breuer and Freud write about the splitting of the personality and how ideas or conflicts may become conscious or unconscious, but apart from the quotation which Janet so much appreciated, they go no further into the nature of dissociation. Janet himself later referred to the relevance of conflict (Janet, 1925) but only briefly, mentioning that Morton Prince had identified conflict as a factor in preventing the recovery of memories. Typically, Freud viewed dissociation as the removal of ideas from one compartment to another. This can be seen very readily in the Introductory Lectures (Freud, 1917, p.248) where he uses the metaphors of rooms and door-keepers for the unconscious and conscious minds. Breuer (1893-1895, p.307) also talks of splitting of the mind rather than of consciousness.

William James (1890) was, like Janet, interested in studying both conscious experience and the phenomenon of illness which might demonstrate changes in memory. In the first direction, he remarked that experience is trained by *both* association and dissociation, and that psychology must be written '*both* in synthetic and in analytic terms' (Vol 1, p.487). His use of the idea of dissociation emphasised that '*what is associated now with one thing and now with another tends to become dissociated from either . . .*' This in turn allows the mind to create an

independent abstraction on some topic. He referred this idea back to Herbert Spencer (Vol 1, p.506). The idea is isolated as the 'law of dissociation by varying concomitants'. Dissociation is a means for correcting ideas of false association. This, however, is clearly distinguished from the dissociation of one part of the mind from another. In this respect James followed Janet, accepting his idea that hysterical patients have a narrow field of attention, and therefore may be distracted from one topic to another, losing the first. Such an approach relies on hypnosis, automatic writing, post-hypnotic suggestion, and similar adventures. Like Janet, he accepted the idea of splitting in consciousness associated with secondary personalities, or of material in hypnosis which is split off and 'dissociated from the rest of the subject's mind' (Vol 2, p.614) (Vol 1, p.384ff).

The more straightforward ideas of dissociation or disintegration have been retained in our idea of the fragmentation of thought processes and consciousness in schizophrenia. Mayer-Gross et al (1954) observed that dissociation of ideas may occur in schizophrenia and they agree with Janet that the most plausible single feature, constant in all cases of hysteria, is the tendency to dissociation – a break-down in central nervous integration (p.123).

The idea of compartments in the mind has been used both in psychoanalysis and in the formulation of multiple personality disorder. It has also been thought that dissociation of consciousness occurs more readily in patients who have had some head trauma with a mild or moderate amnesia, and that even a very partial and temporary disturbance of consciousness serves to start a hysterical dissociation which thereafter might become self-maintaining. Mayer-Gross et al emphasise that the dissociative events in schizophrenia, where emotion may be separated from ideas, are very different from those in hysteria where the dissociation is often transparent in its motivation and thematic in its content, and makes use of dysmnestic mechanisms. Hysterical dissociation is also said to be more massive, while the schizophrenic form is shown in minutiae.

In the practice of hypnosis dissociation has been said to refer to the ability of the hypnotised patient to detach himself from his immediate environment (Kroger & Fezler, 1976). This is described as an ability to 'Step out' of one's self with far-reaching implications for treatment of many types of problems including pain, insomnia, and sexual dysfunction.

DSM-IIIR placed depersonalization disorder within the group of dissociative syndromes. The justification for this deserves investigation. It has to contend with the occurrence of depersonalization in other contexts which include schizophrenic and depressive illnesses, anxiety states, and temporal lobe epilepsy as well as other possible organic cerebral disorders. A small residual group of patients with marked depersonalization in whom none of the other diagnoses appear feasible, has been studied by different authors over the years (e.g. Davison, 1964) without being conclusively allocated either to a group with 'hysteria' or to any other category. Slater and Roth (1980) argue for a strong link between anxiety and depersonalization.

Depersonalization has also been held to be a type of dissociation in which the patient is told under hypnosis to forget who he is and assume the identity of the person he would like to be (Kroger & Fezler, 1976). It should be noted that this is quite different from the standard meaning of depersonalization in psychiatry in which there is a feeling of loss of reality

of the self, often accompanied by feelings of being detached or cut-off from oneself.

For others, dissociation implies a fluidity of 'state' boundaries in hypnosis, e.g. Evans (1972), who refers to 'a fluidity or interchangeability of state boundaries rather than any specific features of . . . dissociated states'. In this condition, hypnosis is conceived of as a trance state. For those who accept hypnosis as a state, this would imply differences in levels of consciousness between different hypnotic states. Its basis as a trance condition still has supporters, the alternative view of hypnosis being that it is in effect a formula for a social role (Barber, 1969). The occurrence of dissociation in hypnosis requires the occurrence of a hypnotic or hysterical amnesia. In response to objections to the validity of hypnotic amnesia, Cooper (1972) wrote 'I am not convinced that the phenomenon of hypnotic amnesia can be entirely explained on the basis of demand characteristics, instructions, expectations, desires to please the experimenter, or role-playing. Over and above all of these variables, there is a responsiveness to hypnotic suggestions that is part of a unique subjective state and which supports the authenticity and genuineness of hypnotic amnesia'. He gives a fair statement of the pros and cons in this discussion, and the present writer favours the cons (Merskey, 1971).

Another paradigm for dissociation has been put forward by Hilgard (1973, 1977, 1979), who offered what he has called 'a neodissociative theory of hypnosis'. He argued that different segments of experience might be accessible or inaccessible to consciousness, depending on the route used to tap sources of information. If an executive ego is in overall control, individual subordinate control systems can sometimes exist in touch with each other, and sometimes not. His leading examples came from automatic writing. Hilgard's theory is also based upon the concept that not everything people do or achieve is consciously intended, initiated or controlled, and that there may be a hierarchical order for mental contents which can be segregated. He argues that hypnotic responsiveness involves a somewhat reduced influence of executive initiative and control over hypnotically enacted behaviour. Thus, 'the planning function is inhibited and the hypnotised person does not independently undertake new lines of thought or action'. Suggestions under hypnosis are held to directly activate subsystems of control. Suggestion to the subject will accordingly bypass normal voluntary initiative and effort. Like other theories based upon hypnosis, this one also is at risk of foundering on the rocks of the argument that hypnotic events can be explained as actions taken for the purpose of particular social roles. In addition, there is an obvious lack of any evidence regarding the qualitative factors involved in shifts between dissociative phases, a problem which may well apply to all theories of dissociation, unless one is prepared to act like the audience at a play and provide the willing suspension of disbelief.

Additions to Dissociation

It would take this discussion too far into a very large field to attempt to review fully the literature on hypnosis over the last five decades, but three arguments stand out. The first is the one that hypnosis may be conceived of as social role-playing, and many experimental demonstrations exist to this effect. The second is that, as Barber (1969) pointed out, all of the valid phenomena that

have been described in hypnosis appear to be attainable through task motivated suggestions. Third, there appears to be no good evidence that physiological changes which have been reported in hypnosis are any different from those which may occur under certain control conditions of arousal. (Some extreme physiological responses are thought to be stage tricks.) Perhaps one of the most interesting and telling demonstrations of the negative effects of physiological investigation comes from a study by Halliday and Mason (1964) which showed that somatosensory and auditory provoked potentials did not change from the normal state when hypnotically induced sensory loss was established by a skilled hypnotist. This finding is the more important because it was not the result which the investigators anticipated (Halliday, 1971, Personal communication).

From the evolution of ideas on dissociation so far, it appears that the main, well accepted phenomena to which the word might be applied are the break-up of mental content, the separation of ideas which were associated, some type of detachment from events, and the gross splitting of ideas or feelings into conscious and unconscious (or accessible and inaccessible) compartments. More detailed lists of dissociative symptoms have also been offered, e.g. in some investigations, a large number of symptoms which arise in relation to shock or trauma have been grouped as dissociative.

Ever since detailed descriptions of psychological responses to catastrophic events began to be offered, a group of quite typical common symptoms has been recognised, whether these occurred in individuals who on their own experienced misfortune, or in groups who were involved in a sudden dangerous and frightening event (cf. Hesnard, 1914). These symptoms included a number of very prominent anxiety symptoms closely related to high arousal, such as terror or fright, accompanied by the usual autonomic responses of dry mouth, piloerection, sweating, palpitation, gastrointestinal changes, and trembling. They also included some phenomena of loss of function such as inability to move or speak. Sometimes panic is accompanied by overactive behaviour such as pushing, jerking, screaming and thrashing about, and similar outbursts. These variations beyond panic, and in the direction of either stupor or agitation, were regarded as hysterical. Kretschmer (1926) provided some plausible reasons why both types of response might be seen to have some value for self-preservation. In today's usage of the terms hysterical and dissociative, to call symptoms hysterical is also to invite their classification with the rubric 'dissociative'. Whether that is justified might be an empirical question, e.g. do such symptoms occur more often in individuals who show classical hysterical symptoms, or are they more notably associated with anxiety and relieved by the treatments for anxiety?

Another range of phenomena has also been mentioned commonly in connection with extreme stress. These include symptoms which could be classified with those of paralysis or withdrawal, e.g. the numbing of sensations which is very common in the face of stress. This numbing is seen as a reduction in the powers both of observation and feeling with a subjective state of being dazed and being unable to concentrate, feelings of detachment, blanks in memory or impairment of memory, somnambulism, i.e. walking about aimlessly without evincing appropriate responses to stimuli, a restricted range of affect, and feelings of detachment, of estrangement from others and inability to recall an important aspect of the event ('psychogenic amnesia'). Following the immediate events, a number of other psychological phenomena which are

usually categorised as post-traumatic anxiety symptoms, are often observed including nightmares, recurrent intrusive thoughts of the original event ('flash-backs'), exaggerated startle response and increased physiological reactivity, and some symptoms which may be associated with depression such as withdrawal, difficulty in concentration, irritability and guilt. Insomnia of course is noted in many cases, and in more prolonged instances, continuing physical complaints concerning headaches, the gastrointestinal system, musculoskeletal pains, and cardiac activity.

Typical symptoms shown by Dutch resistance workers who were previously incarcerated in concentration camps include specific phobias and anxiety related to their incarceration and ill-treatment, flashbacks and difficulties on encountering reminders of their ill-treatment, intrusive recollections and recurrent dreams, sudden acting or feeling as if the traumatic events re-occurred (flashbacks), diminished interest, feelings of detachment, constricted affect, hyper-alertness, sleep disturbance, guilt feelings, memory impairment, avoidance of signals that resemble the trauma, and intensification of emotions at exposure to events resembling trauma (Op den Velde et al, 1993). In this context, it is more than questionable whether any of those symptoms should be regarded as dissociative. It is more appropriate to regard them as the persistent residue of conditioning to intolerable stress.

To what extent are any of the symptoms which have been regarded as evidence of dissociation in response to stress valid indicators of dissociation, and if so, what is meant by dissociation? It would appear that the only symptoms which could be regarded as dissociative are the classical hysterical ones which have long been recognised, like blindness, paralysis, circumscribed or motivated amnesia, hypochondriacal treatment of symptoms, and somatization disorder if it appears. Numbing, which was often combined with fear and anxiety, can be a biological response which provides emotional detachment and a reduction of the harsh impact of enormously threatening stimuli. The consequent difficulties in concentration and memory would be both physiologically and psychologically inevitable, and we are forced to think again about what other symptoms can be called dissociative.

In other words, although stress is a well-authenticated cause of dissociative disorders (witness shell-shock) the symptoms which are found in the typical post-traumatic pattern are most often anxiety, and should not be characterised as dissociative without specific justification.

Reviewing the extensive, detailed contents of the latest volume on post-traumatic stress disorder (Wilson & Raphael, 1973), it becomes evident that the classical responses of hysterical symptoms are remarkably rare in the 84 chapters and 988 pages of text. Some cases of multiple personality disorder are attributed to past trauma, but the strongest statement on possible avoidance or denial of symptoms is to be found in a discussion of torture victims (Agger & Jensen, 1993) which quotes Horowitz's views emphasising the place of denial and avoidance in those who have been subjected to repeated ill-treatment. Formal classical hysterical symptoms are remarkably rare, particularly in comparison with any of the literature on the First World War, where such material abounds (Merskey, 1991).

The principal interest in dissociation in modern times focusses upon its use as an explanation of puzzling psychological events connected with amnesia.

Its other meanings receive little attention. Currently, DSM-III[R] defines it as 'A disturbance or alteration in the normally integrated functions of identity, memory, or consciousness'. In itself, this leaves open the question of whether compartments in the mind might be utilised and whether clear splits occur between different functions. However, even the most cursory inspection of the rest of the section on dissociative disorders in DSM-III[R] makes it quite clear that the term is being used to describe such phenomena. Multiple personality disorder is the first and almost overwhelming example of this usage, but psychogenic fugue and psychogenic amnesia are both subject to it as well. Depersonalization disorder is also offered, interestingly, as an example of dissociation, marked by an experience of feeling detached from, and as if one is an outside observer of, one's mental processes or body.

This may serve as a starting point to consider phenomena which are currently attributed to dissociation, but which were not all part of the original discussions when dissociation was born. Putnam claims that dissociation occurs in both minor non-pathological and major or pathological forms (Putnam, 1989, p.6) and this is supported by a number of other authors in the literature. Daydreaming is described as a minor dissociation of everyday life, and multiple personality is a major pathological form. Other symptoms which reflect dissociative phenomena are held to include amnesia, profound detachment, depersonalized feelings during moments of extreme stress, out-of-body experiences, and dreamlike recall of events, and these are said to occur more often among combat veterans (Putnam, 1989). Apart from amnesia, all these experiences involve conscious awareness of the whole process, although in an altered fashion. Flashbacks and abreactions are seen as well as more definite dissociative events with some compartmentalisation of experience.

The validity of this process – at least for a number of symptoms - is questionable. Empirical studies are lacking which demonstrate, for example, that all such symptoms are linked strongly to dissociative disorders – other than MPD which is essentially artefactual. The definition of dissociation is so broad that it will encompass everything from selective focussed attention on an arithmetical calculation while ignoring a thunderstorm, to sleep-walking or an episode of complete amnesia for personal identity. Some of these symptoms have little if any face validity, e.g. detachment and depersonalization.

Interest in dissociation has led to efforts to develop scales for screening purposes or for diagnosis. It might be possible to detect the meaning of dissociation from the operational features of these scales. The Dissociative Experiences Scale (DES), developed by Bernstein & Putnam (1986), relies upon answers to 28 questions recorded on a visual analogue scale, 150mm in length. The items include missing part of a conversation, remembering the past so vividly that one seems to be reliving it, being able to ignore pain, talking out loud to oneself when alone, looking at the world through a fog, finding evidence of having done things one cannot remember, driving a car and realising that one does not remember what happened during the trip, not recognising one's reflection in a mirror, finding oneself in a place but unaware of how one got there, and finding unfamiliar things in one's belongings. This scale has been used for screening purposes and Ross et al (1989) report scores among acute care general adult psychiatric patients. They interpret the response to four items (not recognising friends or family, finding oneself in a place but unaware how

one got there, finding unfamiliar things among one's belongings, and finding oneself dressed in clothes one cannot remember putting on) as indicating that 6-8% of general adult patients may have multiple personality disorder (MPD). They argue also that this scale shows that dissociative psychopathology is common on inpatient units.

If one subscribes to the diagnosis of MPD, and also defines abstraction, detachment, pre-occupation, forgetfulness, and so forth as evidence of dissociation they may be right, but the validity of doing so remains open to question.

Sandberg & Lynn (1992) used the DES to identify a sample of 15% of the general population who scored high with this measure. They found that among this sample, 6% (2 subjects) met criteria for a dissociative disorder. Among a control group of the same size from the other end of the scale, none had a dissociative disorder. Eight other subjects who scored in the top 2% of the population on the DES had no diagnosis of a dissociative disorder. As a screening test to find individuals with dissociative disorder among 15% of the population, the test allows one to ignore 85% of those who would otherwise have to be interviewed, but interviews could only be expected to yield approximately one case for every 20 examined from the remainder. Quite apart from this weakness, the test can hardly be taken to be a valid indicator of dissociative disorder as defined by DSM-III-R (i.e. either MPD or psychogenic amnesia).

The Dissociative Interviews Schedule (DIS) which Ross has described (Ross et al, 1989) is a schedule with 131 questions which the authors say can be completed even for cases of complex multiple personality disorder within three-quarters of an hour. Half the schedule is devoted to recognising other psychiatric conditions such as depression. Responses held to indicate dissociation include trances, sleep-walking, having had imaginary playmates, childhood sexual abuse, answers to 11 questions about amnesic episodes, blank spells, failure to recognise possessions, and a person inside which emerges or takes control (this group reflecting MPD), as well as other questions which might identify psychogenic amnesia, psychogenic fugue and depersonalization disorder. Besides high reliability, this schedule is claimed to have good clinical validity on the basis of a sensitivity of 90% and a specificity of 100% for the diagnosis of MPD. Critics can argue that this does not establish construct validity. What we have seen is an energetic attempt to broaden the concept of dissociation without consideration for the fact that many of the phenomena selected may be more representative of anxiety.

Frankel (1989) pointed out that there is considerable current discussion on the nature of dissociation, and provided evidence on the relatively high hypnotic susceptibility of phobic patients compared with smokers who sought to quit smoking through hypnosis (Frankel & Orne, 1976). This tendency of anxious subjects to be good hypnotic subjects has long been known, but reliance on hypnotic susceptibility as measured by the Stanford Scale, or other scales, in identifying dissociative tendencies can be misleading. Frankel also points out that the issue of a continuum in regard to dissociative experiences is still open to question. On reviewing the history of the term 'dissociation', he says it is apparent that clarity is conspicuous by its absence. The core of the phenomenon is fairly readily recognisable and can be agreed upon, but as soon as one moves away to consider the other shades of experience, matters become less clear. The idea that something is disconnected or that there is a lack of integration of knowledge, identity, memory, and control is at the core, and when these features occur in

typical cases, he finds virtual consensus that they represent dissociation. Beyond those conditions, however, when we discuss phobias or post-traumatic syndromes, the presence of dissociation or detachment is not necessarily the predominant characteristic and the less dramatic factors of suggestibility, denial, repression, frozen affect, emotional detachment, and inhibition, plus the consequences of alterations in attention, perception, motivation, imagination, or memory cannot be ignored. He also points out that the interchange of the constructs of hypnotisability and dissociative capacity should be avoided.

The development of scales to measure dissociative experiences has been linked to the advocacy of the diagnosis of multiple personality disorder. This diagnosis has received determined criticism from several quarters, to be discussed below. Nevertheless, the development of such scales should not be rejected simply because of the bad company which they have kept. However, since the scales offered so far combine a number of items of behaviour or experience which have not been shown to have a strong link with dissociative disorders, judgement has to be reserved about the present versions.

Multiple Personality Disorder

Since the decay of shell-shock, multiple personality disorder (MPD) has been the largest growth area for conversion or dissociative disorders. The first supposed case of MPD recorded in detail is that of Mary Reynolds of Pennsylvania (Mitchill, 1816; Plumer, 1860; Mitchell, 1888). From 1816 until 1944, a period of 128 years, some seventy-six cases were identified (Taylor & Martin, 1944), amounting to a rate of about one every two years. In 1954, Thigpen and Cleckley reported a case. Their book 'The Three Faces of Eve' appeared in 1957 and a film was made of it. Another book (Schreiber, 1973) followed, about a patient called 'Sybil' and her story was also made into a film. Thereafter, the numbers of cases reported grew substantially, and from 1980, when DSM-III-R (APA, 1980) offered a category and a definition, the numbers expanded even more, so that currently, there are claims, e.g. Ross et al (1989), that as many as 6-8% of all general hospital psychiatry patients may suffer from the disorder. Among individual psychiatrists, Kluft (1982) reported seeing 130 such patients and treating 70, Bliss and Jeppsen (1985) mentioned seeing 100, and Putnam et al (1986) reviewed 100 cases.

Not only are many cases seen, but numerous cases have many personalities. Schreiber's case had 16, Eve developed 22 (Sizemore & Pittillo, 1977), and Kluft (1982) described 60 cases in some detail, of whom only 11 had two personalities, 8 had three to five personalities, 20 had six to ten personalities, 19 had eleven to twenty personalities, and 2 had more than twenty personalities. Hilgard (1988) observed that such numbers 'as well as those reported by several others, are bound to raise doubts about diagnoses'.

On a much smaller scale, Hacking (1991) has chronicled a similar growth of cases of double consciousness in the 19th century. His study includes the discovery of a number of cases which might be added to the classic 'canon', and he traces a cascade effect following initial reports. Hacking (1992) estimated that the reports of numbers of cases occurred in waves. Thus, a report by Dwight (1818) following the initial brief report about Mary Reynolds by Mitchill,

describes three cases seen in 1802. The first wave, with very few cases, essentially lasted until 1875. A small increase occurred after 1875 with the publication of the cases of Janet, followed by Azam. After Morton Prince's work, another group of cases appeared from 1920 to 1926, following which there were only occasional ones until the onset of the modern explosion.

For the greater part of the 19th century, the term used to describe such cases was 'double consciousness'. It was regarded as common usage in Scotland by February 1822, when Dewar (1823) communicated an 1815 case of Dr. Dyce of Aberdeen. In France, both Azam and Janet used the words 'doublement de la vie' or 'la double conscience' and occasionally 'le doublement de la personnalite'. After 1876 the latter form became standard for French writers, and then Myers (1886) used the phrase 'Case of double or multiple personality' which by 1885 had become the received phrase used by Ribot and Janet. However, even so, in the whole of the 19th century there were only some 20 cases, apart from a small additional group which Hacking (1991) has since identified.

The remarkable recent growth of cases and the large numbers of personalities provoked questions on the part of other psychiatrists. The fact that the diagnosis either did not occur or was extremely rare in Britain (Mayer-Gross et al, 1954; Aldridge-Morris, 1989, p.15), Japan (Takahashi, 1990), New Zealand (Altrocchi, 1992), or Switzerland (Modestin, 1992) provoked comment by both sceptics and believers. Critical voices ultimately emerged who offered a substantial review of the topic, the majority of the sceptical opinions being published first in Britain.

Kenny (1986) examined the biographies of five prominent reported cases from an anthropological perspective and found it to be a play on social roles that could be properly understood only in reference to the current cultural set of 'ideal types' or 'root paradigms', and regarded the diagnosis as lacking in explanatory adequacy. He suspected 'cultural bias and a covert process of selection, that direct certain kinds of patients to therapists inclined to diagnose their problems in terms of multiple personality'. It was an artefact to which both doctors and the rest of the environment could contribute. Fahy (1988) maintained that the literature lacked information on the reliability of diagnosis, prevalence, or the role of selection bias, that iatrogenic factors may contribute to MPD, and that there is little evidence from genetic or physiological studies to suggest that it represents a distinct psychiatric disorder. Aldridge-Morris (1989) called it an exercise in deception and saw it as a cultural phenomenon.

Merskey (1992a) noted the lack of cases in past descriptions of groups of patients with hysterical disorders, as well as the epidemiological and methodological problems to which others had drawn attention, and argued that widespread publicity for the concept makes it uncertain whether any case can now arise without being promoted by suggestion or prior preparation. However, it seemed possible that there might have been some cases – before the days of widespread comment – which arose spontaneously and in which it might be possible to study the origins of the transformation into a second or third personality. The search for such instances proved fruitless in one sense and astonishing in another. I found that the classic cases of the 19th century which were adequately described fell into three groups: organic disorder, which was generally recognised and had subsequently been discounted; rapid cycling bipolar affective disorder or manic-depressive illness; and direct suggestion under hypnosis. The early cases

such as Mary Reynolds and the case of Skae (1845) were obvious cases of affective disorder. Almost all cases treated by Janet and the French school, were given their extra identities under hypnosis. There were no grounds for thinking that a true spontaneous case had ever occurred, and the growth of the notion appeared to have been closely related to the use of hypnotic suggestion.

Examination of some of the more modern cases also raised questions. Thigpen and Cleckley's case 'Eve' was recognised as a woman with a very unhappy marriage, who was under regular treatment at a psychiatric hospital for headaches and who, when her first switch of personality occurred, simply reverted to her maiden name. 'Sybil', the other most famous case of the second half of the 20th century, was a student of psychology who spent a great deal of time in libraries reading about psychiatric diagnoses. Other weaknesses in the current concept were also noted. Overt suggestion and the recruitment of cases by active specialists in the field of dissociation were very evident, e.g. Putnam (1989, p.90) recommended indirect enquiry at first but otherwise direct search for any part or label that might be obtained. Merskey (1992b) argued that multiple personality disorder was a 'doxogenic' diagnosis, i.e. one caused by thoughts of its existence.

Cases soon emerged of patients in whom the diagnosis of multiple personality disorder had been given inappropriately. Fahy et al (1989) were the first to describe a case where the diagnosis was entertained by the patient but discouraged and declined. Freeland et al (1993) reported four patients who had been given the diagnosis by doctors or other therapists, and in whom alternative diagnoses were preferred. Meanwhile, MPD has not been recognised as a substantive category for the International Classification of Diseases in its tenth revision (ICD-10, 1992), but remains in the projected DSM-IV, with only a minimal change in the criteria to require that extensive personal information should have been forgotten by one of the personalities.

The medico-legal implications of MPD are striking. There is no dispute that it can be simulated. The most notable case of simulation was that of Kenneth Bianchi, the 'Hillside Strangler', a serial killer who developed multiple personality disorder under the influence of a defence medical examiner. Orne et al (1984) describe the disproof of the claim to MPD. In another instance WS Milligan, who had committed repeated rapes, was found not guilty by reason of insanity, that is MPD (Keyes, 1981) and committed to a psychiatric forensic institution. Slovenko (1989) has aptly described the multiple personality as a challenge to legal concepts. The interested reader may find this latter article a useful starting point into the literature.

Adequate information about the distribution of opinions is not available. Orne and Bauer-Manley (1991) observed polarisation between '... a relatively small group of therapists ... reporting large numbers of cases (increasingly with large numbers of 'personalities' in each case) and others who believe that if MPD occurs spontaneously at all, it does so extremely rarely'. Merskey (1993) obtained a small sample of professional opinions among colleagues who requested a reprint. This cannot be regarded as representative of the medical and other professional populations, those who wrote for reprints perhaps being polarised themselves, but the results showed that from 90 reprints sent out with forms, 44 forms were returned of which 38 were analysable. After reading the reprint, 4 held that multiple personality disorder was a valid entity

and quite common, 15 supported the view that it occurred occasionally, and 19 rejected the diagnosis. A survey of a lay audience produced somewhat similar results.

Historical Insights

Medical writers often noted that the concept of hysteria originated from Greek authors and was related to the idea that the womb moved about the body. It was also long-recognised that not all Greeks supported the idea of a wholly wandering womb, and Galen (Siegel, 1976) in particular had rejected it. Many also failed to notice that the most striking example of this view was not taken from a biological source, but from a dialogue or philosophical discussion, in Plato (*Timaeus* 91B-C) where in likening sexual desire to an actual animal, Plato first mentions '... in men the organ of generation becoming rebellious and masterful like an animal disobedient to reason', and then alludes to 'the womb being ... desirous of procreating children and ... when remaining unfruitful long beyond its proper time, ... wandering in every direction through the body, closes up the passages of the breath, and, by obstructing respiration, drives them to extremity, causing all varieties of disease ...'. Veith (1965) conducted a very substantial review of the literature on hysteria, which still serves as a useful, although not wholly reliable source for relevant historical information. One weakness in Veith, to which attention has lately been drawn, was the propagation of the idea that the Greeks derived their notions about the wandering womb from the ancient Egyptians. Little more was said about the history of hysteria, except for a recognition of the changes in ideas about it which commenced approximately with Brodie (1837) and proceeded through the work of Charcot and Freud to the identification of conflict and motive as problems underlying the production of hysterical symptoms (Merskey, 1982).

Merskey and Potter (1989) have argued that there was no real evidence to justify the claim that the Ancient Egyptians believed that the womb wandered, and particularly the claim that it caused globus hystericus. This conclusion was based upon an analysis of the different translations into English and German of the original hieroglyphic texts. An analysis of the Greek Hippocratic sources, translated by Littré, (Merskey & Merskey, 1993) also offers a relatively natural interpretation of the notion of the wandering womb. Our reading of the relevant Papyri in translation suggests that most of the information which had been interpreted in terms of the wandering womb was principally concerned with the restoration of the womb to the abdomen after prolapse. Pregnancy would be the most obvious condition in which changes in the womb would be liable to affect breathing, which would be one explanation for the postulated effect on the channels of respiration. The other factor to be considered is the frequency of anxiety in women with palpitations, dryness of the mouth, difficulty in swallowing, and dyspnoea. Merskey and Merskey (1993) suggested that the description of hysteria as due to the womb would be better understood as a recognition of anxiety occurring more frequently in clinical practice in women than in men.

In addition to some refinements of the traditional appreciation of hysteria, there have been a number of publications on very specific topics, e.g. Anna

O., Breuer and Freud's first case. As many as 14 different reinterpretations of her condition were offered in one volume (Stewart, 1984). The diagnoses put forward include a toxic psychosis based on morphine addiction, MPD or 'a double personality' (Ellenberger, 1980), and schizophrenia (Goshen, 1952; Reichard, 1956; Bram, 1965). Meissner (1979) spoke of a borderline state. Thornton (1983) argued in favour of tuberculous meningitis, Hurst (1982) favoured sarcoid, and Orr-Andrewes (1987) suggested complex partial seizures. None of these diagnoses except for the diagnosis of a double personality or MPD (induced by Breuer's repeated hypnotic sessions) seems particularly apt. Spitzer et al (1981) suggested that, major affective disorder was one of her diagnoses, and Merskey (1992) argued that on the basis of recent historical information, especially that provided by Ellenberger (1970) and Hirschmuller (1989), the principal diagnosis was a severe depressive illness with depressive delusions, complicated by hysterical symptoms which could be understood as part of the depressive state, modified by the interventions of her physicians. The basic illness was later complicated by dependence upon morphine and chloral hydrate, the patient subsequently making a very impressive recovery, and leading an effective and fruitful life which demonstrated the resilience of the cyclothymic temperament. Weissberg (1993) has lately argued with good justification that the diagnosis of MPD in Anna O. was due to Breuer's treatment.

In a substantial historical volume, Shorter (1992) claims that chronic fatigue syndrome is the modern equivalent of Victorian paralysis. Although his argument was immediately criticised by those who feel that there is biological evidence of an independent chronic fatigue syndrome, the volume is noteworthy for its extensive information about European diagnoses and the practice of hypnosis in the 19th century. Other contributions have included a splendid study of the life and work of Josef Breuer by Hirschmuller (1989) which, incidentally, establishes the fact that the concept of hysteria when Breuer was treating his first patient, Anna O., was that of any general neurosis without specific localisation, i.e. the concept covered a range of psychological problems including many phenomena that we would now take to be anxiety or depression.

An equally impressive study of 19th-century Victorian psychiatry by Oppenheim (1991), although dedicated to patients with depression, provides many helpful side-lights on the 19th century understanding of hysteria. Alam and Merskey (1992) reviewed the development of the hysterical personality while with the exception of Veith, Trillat (1986) has provided the only book-length study of the history of hysteria during the period under review. No discussion of recent contributions to hysteria would be complete without a reference to Micalé's substantial historiographical work (Micalé, 1989a and 1989b, 1990a and 1990b). He has demonstrated Charcot's influence throughout Europe, particularly with respect to the ideas of hysteria in men. One other historical development of note is the re-publication of Edward Jorden's classic book on the Mary Glover case, with associated documents and an introduction by Michael Macdonald (Macdonald, 1991). Although these publications are by no means confined to hysteria, they reflect the continuing interest in its social and psychological significance, as well as in its medical importance. In a decade during which the term disappeared from the nomenclature of the American Psychiatric Association and was replaced by dissociative disorders, conversion disorders,

histrionic personality, and somatoform disorders, the broad topic has continued to attract a large measure of attention.

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6 LMF in Bomber Command 1939-45: diagnosis or denouncement?

SYDNEY BRANDON

W.H. Rivers, a neuro-physiologist who turned to psychoanalysis, was brought in to work with the Royal Flying Corps after his success in treating shell shocked army officers at Craiglockhart Military Hospital. In a brilliantly researched series of novels, including the Booker Prize-winning *The Ghost Roads* (1995), Pat Barker has given some account of his work with a distinguished company of patients including Siegfried Sassoon, Wilfred Owen, and other war poets. The Medical Research Committee then made it possible for him to work at Magull Military Hospital and with the Royal Air Force on 'the varied psychological problems presented by Aviation in time of war'. This experience formed the basis for his book *Instinct and the Unconscious* (1920) in which he observes that, 'traumatic neurasthenia, is especially known as the sequel of railway accidents, and since this form of neurosis closely resembles that due to warfare, our knowledge of war neurosis might have advanced more rapidly if this had been taken as a guide'.

Another early pioneer of the study of psychological problems in military aircrews was Dr James Birley, the father of a recent President of the Royal College of Psychiatrists. He was also one of the members of the War Office Committee of Inquiry into Shellshock (1922) which struggled with the dilemma of distinguishing between cowardice and the stress of combat in World War I, and failed to reach a satisfactory conclusion. In a scholarly review of cases shot for 'cowardice' during the first world war, Judge Anthony Babcock (1983) demonstrated that a substantial majority of the cases were men who either never should have been accepted for enlistment because of their psychiatric disability or were suffering from the effects of combat stress.

This confusion remained at the beginning of the second world war, during which 'LMF' ('lack of moral fibre'), stamped on the documents of an aircrew member, brought disgrace and humiliation. In the Royal Air Force, the Neuro-psychiatric Division was responsible for psychiatric care and prophylaxis, but most of its medical officers were neurologists; few had extensive psychiatric training or experience, and their understanding of stress reactions or neurosis was limited.

The distinguished neurologist Sir Charles Symonds was wartime head of this division, and has been identified by many as the originator of the LMF concept. However, my review of the scanty documentation available shows that he played no part in its development and raised objections to the practice (Symonds, 1942

a &b). The procedure was essentially administrative and probably originated in the office of the Member for Personnel of the Air Council, which was then the highest level of administration in the RAF.

To understand the origins of this policy, it is necessary to appreciate that even in wartime, the Royal Air Force was an entirely volunteer service. Conscripts could opt for the RAF and were admitted if they passed the educational and other selection procedures. Men were first enlisted in the RAF and then had to volunteer for air crew duties, and only if they were able to pass the rigorous physical, educational, and other selection procedures were they then accepted for training. Thus, they were twice volunteers and their determination had been tested before they began training. Unlike the current concept of 'informed consent', once accepted, it was not possible to withdraw. Refusal or inability to continue to fly, in the absence of sufficient medical cause, was regarded as indicative of moral weakness. It was reared that the exhibition of such 'moral' weakness would have a detrimental effect on the morale of others facing danger (Balfour, 1973).

A certain glamour attached to the service whose members were known as the 'Brylcream boys'. The mystique of flying had an almost universal appeal; most small boys wanted to be fighter pilots, and the Battle of Britain, hailed as a remarkable victory due to the 'Few', gave all in RAF uniform a special standing. At no time during the war was there any shortage of volunteers for aircrew duties, and this is remarkable when one considers just how dangerous flying was in those days. Many of the front-line aircraft were even then obsolescent and required great skill to merely prevent them from crashing. Some had unpleasant habits such as a liability to swing off the runway on take-off, as well as stalling or spinning tendencies which would have been unacceptable in a civil aircraft.

There is a well known adage, 'Only birds and fools fly and only fools fly by night', yet on completing training, most aircrew were then asked to fly at night, carrying large amounts of high explosive, hundreds of miles over hostile territory where 10% of Germany's industrial might was devoted to the sole purpose of destroying them. They had to return, harassed by defenders all the way and using primitive navigational systems, struggling to reach inadequate airfields which were often covered in cloud or fog. What is remarkable is not that some failed to show aggressive spirit, but that any could be persuaded to do this and to do it night after night despite heavy casualties in their squadron.

Recruitment

While well aware of the dangers, the Air Ministry were anxious to secure and maintain a constant supply of volunteers. This was the particular responsibility of the Air Member for Personnel.

The RAF was from its earliest days referred to as the 'cavalry of the Skies', and took some of its attitudes and traditions from the prestigious Cavalry Club. Flyers were the cream and had to be gentlemen, who differed from members of the elite cavalry regiments only in the additional requirement that they must be intelligent.

Before the war, direct entry to pilot training was available to young men from good public schools who had shown that they were of the 'right stuff' by their

prowess on the sports fields, hobbies such as hunting and shooting, and their social connections. With few exceptions, they were commissioned and continued in the RAF mess to live the privileged existence their school had prepared them for. Courage was regarded as essentially a function of character, which could be deduced from a young man's background and experience, as well as from evidence of certain characteristics such as 'a good eye for the ball', a 'team player', and 'not too much imagination.' The Auxiliary squadrons, which did such noble work during the Battle of Britain, were gentlemen's clubs where the county aristocracy and the independently wealthy could learn to fly in congenial company.

Recognising that the RAF and its auxiliaries could not meet the demands of total war, the Royal Air Force Volunteer Reserve was created in April 1937 to recruit from the industrial areas and 'the whole range of secondary school output' (Richards, 1953). When war came, these sergeant pilots reinforced the pre-war elite and served with great distinction.

A massive Empire Air Training Scheme was established in May 1940 to meet the demand for large numbers of aircrew and more rigorous selection procedures were established to screen the volunteers who were now coming from all walks of life. By the time it closed in March 1945, they had produced 137,739 members of aircrews (Saunders, 1954). However, these wartime volunteers were enlisted not into the RAF, but into the RAFVR. Their success in training and in combat fully justified the reluctantly adopted egalitarian policy, but the Air Council and many in the command structure continued to worry about the reliability of these entrants from the lower social classes.

Once they obtained their flying badge, they were given sergeant's stripes and lived in the sergeants' mess, separated from the officers of the squadron, even though they might be members of the same crew. However, a small number were commissioned on graduation and a few more, who survived their first tour, received direct commissions.

In the sergeants' mess, this vast influx of youthful NCOs was less than welcome. The original inhabitants were highly skilled men who had served for many years before they obtained their first stripes, and waited many more before each promotion. Few became Flight Sergeants and even fewer reached the dizzy heights of Warrant Officer. By contrast, these new arrivals were sergeants while still in their teens in many cases, and obtained their crown or warrant with apparently indecent speed.

To the young volunteer, however, the glamour of air-crew status, the prospect of rapid promotion, flight pay and even the possibility of a commission were attractive alternatives to call up into the army, where there was little prospect of promotion and the strong possibility of rapid posting to unpleasant places. Aircrew cadets even slept between sheets and wore comfortable shoes instead of hobnailed boots. Flying training was exciting and many who volunteered were fascinated by flying. There were, however, significant numbers who were either indifferent to the joys of flight or actually apprehensive about losing contact with *terra firma*. For many of these men, being in the air required a considerable effort of will.

Two maxims originating with the cavalry are, 'if you are thrown from your horse, get back on again at the earliest opportunity', and secondly 'don't panic'. Many instructors insisted that a pupil involved in a crash should take to the air

again as soon as any injury permitted. Others regarded this as a harsh policy and both junior commanders and medical officers sometimes preferred to send the victim on a brief period of leave. Indeed, 'survivor's leave' became a standard policy on operational units, but recent developments in understanding the origins and management of phobias (Marks, 1987) show that the cavalry had been right.

Another instructors' maxim was, 'whatever you do, don't panic', for it decreased effectiveness and was habit-forming. Again, current views on panic disorder and post-traumatic stress disorder (PTSD) (APA, 1994) lend credence to this view. If a pilot nervously enjoying his early experiences of solo flight attempts some manoeuvre which puts him into an uncontrolled spin, the ability to detach himself from this potentially lethal situation facilitates his use of theoretical knowledge to extricate himself. The student who panics and blindly attempts a variety of control movements may actually recover as a result of his efforts or of the inherent stability of the training aircraft – possibly very near the ground and the prospect of death. He may survive, but have a considerable residual fear of flying.

Since over 8,000 men were killed in accidents while in training, many men started with some fear of flying and more acquired such fears during their training. By and large, during training they were masters of their own fate, but once in a Bomber Command Operational Training Unit (OTU), they were either dependent on someone else or directly responsible for the lives of others. 'Crewing up' was a random affair and the crew which chose a pilot who seemed a 'decent chap' might find that he was below average in flying skills, always having extreme difficulty in take-off and landing. So a new terror might be added to every flight. It is thus not surprising that nearly one-third of those who dropped out of flying did so before they reached an operational unit. The official view often assumed that such individuals had volunteered for aircrew duties for selfish reasons, such as the privileges or the glamour, but could not face up to the prospect of facing the enemy.

Both training and operational flying were hazardous, and the loss for any reason of highly selected and trained volunteers could be ill-afforded. Anticipating crew shortages, aware of the need to maintain morale and to a lesser degree anxious about the competence of ordinary medical officers to assess psychological fitness to continue flying, the Chief of Air Staff convened a meeting in 1940. This was to consider the issuing of a policy letter dealing with operational fatigue, length of tours of duty, and the management of 'flying personnel unwilling to face operational risks'.

This meeting was attended by the Air Member for Personnel, Air Marshal C.F.A. Portal, who was later to replace Air Chief Marshal Sir Edgar Ludlow-Hewitt who attended as Commander in Chief, Bomber Command, and by Air Vice Marshal J.E.A. Baldwin, Air Officer Commanding 3 Group. The result of this meeting was a letter which outlined the procedures for identifying those 'whose conduct may cause them to forfeit the confidence of their Commanding Officer' (Air Ministry, 1940a). Such individuals were thought to fall into one of two categories: those who were 'medical cases' and those whose determination and reliability in the face of danger were questionable and who were labelled 'lacking in moral fibre'. This is the first identified use of the term, which was probably coined in the office of the Department of the Air Member for Personnel

(McCarthy, 1984). This letter, dated 22 April 1940, left a number of uncertainties, particularly regarding the role and responsibilities of medical officers. An Air Ministry Pamphlet 100, dated May 1939, had charged squadron doctors with responsibility for 'keeping airmen at the highest possible pitch of efficiency', while detecting and promptly treating men who might display physical symptoms of combat fatigue. They were, however, cautioned against over-enthusiasm in this, for it "would not do to create an expectation of nervous breakdown." (Air Ministry 1939a).

The Director General of Medical Services (DGMS) issued a confidential addendum to the pamphlet, confirming the necessity of distinguishing between cases of diagnosed illness and 'non-symptomatic cases.' This also warned that 'it has been noted that there is a tendency for medical officers to assume too readily that lack of confidence to fly or fear of flying are necessarily symptomatic of nervous illness and justify exemption from flying duty on medical grounds. Pilots or members of aircrews are thus not infrequently taken off flying with the label "psychoneurosis" without adequate investigation or assessment of their symptoms' (Air Ministry, 1939b).

A letter to Commands dated 28 September 1940 (Air Ministry 1940 b) signed by Charles Evans, Principal Assistant Secretary for Personnel (later known as 'the waverers' letter') set out the LMF disposal policy. The key players were identified as the Commanding Officer and his Medical Officer. Men identified as showing evidence of physical or nervous illness were to be treated on the station, and subsequently recommended for leave or transferred to hospital. If the diagnosis was unclear, they could be referred to the newly established NYDN (Not yet diagnosed neurosis) centres (Air Ministry, 1940 c), modelled on those established in World War 1. Here, the neuropsychiatric specialist was required to make the final diagnosis and arrange appropriate disposal. Medical officers were required to notify the commanding officer of men in whom no evidence of illness was found and who thus 'lacked moral fibre'. The squadron and station commander were to prepare a report, which was to be shown to the individual who was thus accused.

The Air Officer Commanding (AOC) at group level was then informed and, having reviewed the medical officer's reports and the man's operational history, then made a report to the Air Council. In fact, these went to a staff officer in the Director General for Personnel's office, Wing Commander J. Lawson whose post-war memo is one of the few accounts of the LMF policy. (Lawson, 1945) The accused could request an interview with the AOC and appeal against the recommendation, but once it was considered at Air Council level, it was passed to the Secretary of State's office for final confirmation. If confirmed, 'LMF' was stamped on the personal documents, officers were then usually cashiered, NCOs were reduced to the lowest rank of aircraftsman second class (AC 2) and were either employed on menial duties or discharged, and then either immediately called up into the army or directed to work in the mines. Steps were taken through the Ministry of Labour to ensure that cashiered officers and discharged men were not employed in well paid or high-status occupations.

Symonds feared that inexperienced Medical Officers were being asked to make *de facto* judgements regarding lack of moral fibre. He and his colleagues were critical of the underlying philosophy and critical of the tone and intent of the

'waverers' letter.' His views were expressed in several memoranda written to the Under Secretary of State for Air in 1942 (Symonds 1942 a & b).

Lord Balfour of Inchrye was Under-Secretary of State for Air during the war, but in the first world war, as Captain Harold Balfour, had served as a fighter pilot on the Western Front. The files on LMF cases with the views and recommendations of the Air Member for Personnel came to his desk.

The majority of cases came from Bomber Command. LMF was dangerously contagious. One LMF crew member could start a rot which might spread not only through his own crew, but through the whole squadron, particularly when there happened to be a lot of inexperienced crews replacing casualties. Directly a case of LMF showed, the first and vitally important step was to remove him from all contact with other aircrew personnel. He would be posted to a depot while his case was considered. . . . Whatever faults of judgement I may have made during my time at the Air Ministry and, looking back, there are quite a few, my conscience is clear about dealing with LMF cases. Always in the back of my mind the knowledge that right through the war every man who flew had started off as a volunteer. (Balfour, 1973)

This extract encapsulates the official view that true volunteers were cast in a heroic mould and could not withdraw their consent. It also illustrates the belief among senior commanders that LMF was a highly contagious state which could spread like wildfire. The first belief is ethically questionable and the second is not supported by any evidence. Aircrews were themselves on the whole sympathetic towards their fellows who were 'twitched', provided that they continued to function effectively, and where a crew member became a liability they often encouraged them to 'see the doc'. Crews did not regard the condition as contagious. The cohesion of the crew provided a support network in which they shared their dangers and their social life, usually liberally lubricated by alcohol. Crews often lived in a microcosm with comparative isolation from all but one or two other crews in the squadron. Some argued that crews under stress could often be identified and that this was predictive of their early loss, but there is nothing except anecdotal evidence to support this view.

Some consultant neurologists serving in the RAF Medical Branch as 'Neuropsychiatrists' expressed the belief that 'cases' of LMF could be identified easily, since they wore dark glasses in the mess or had 'handle-bar' moustaches, the tips of which could be seen from behind (Rollin, 1990). There is no doubt that a keen General Duties Medical Officer could help sustain many who were showing signs of strain. Dr Roland Winfield, while serving as a Bomber Command Medical Officer, trained as a pilot and flew 120 sorties, being awarded the Distinguished Flying Cross and the Air Force Cross. He understood the problems faced by aircrew and was often able to restore the confidence of men who were beginning to 'crack up' (Winfield, 1976).

Another young and inexperienced doctor who found himself Station Medical Officer on a bomber base made a point of getting to know the crews and to fly with them. His empathy and concern kept many men flying or sent them for specialist treatment, rather than executive action. This experience led David Stafford-Clark (1993) to train in psychiatry after the war.

There is a surprising paucity of documentation on LMF. The Lawson memoir

(1945) is the only document on the subject in the possession of the RAF Historical Branch and it is rumoured that most of the relevant records were destroyed after the war on orders from 'the highest level.'

The story of two survivors of the system (Brandon, personal interviews, 1993) are of interest.

Case 1

A Warrant Officer pilot was serving with an Army Co-operation Squadron when an urgent request was received to despatch two hundred Spitfire aircrew to North Africa. Having just completed a Spitfire conversion course he was sent with the draft to North Africa. On arrival the 200 were informed that they were not required as the signal should have read '200 Spitfire aircrews are required.' For some time he ferried newly arrived aircraft to their units, but hearing that a squadron in Italy was desperate for replacements he volunteered to join them. At this time the squadron were flying many sorties every day in a fighter/bomber role against targets in Yugoslavia. They were suffering considerable casualties and after three months of continuous operational flying, his flight commander told him that he needed a rest, suggesting that he and two other pilots should have a weeks leave in Sorrento. The CO agreed and set the date for the following week. The next day his flight commander was shot down and on the following day the CO failed to return.

The CO's replacement was a South African Air Force Major with little operational experience. One of his first acts was to send for the three pilots who had been booked for leave and to tell them that he understood that they were 'waverers' and he did not want the likes of them in his squadron. The Warrant Officer invited the Major to fly sorties with him but this invitation was not taken up. He continued to fly sorties over the next few days until sent for by the Group Commander, who interviewed him and told him he had 'lost his nerve.' He was posted out of the squadron and only when he reached the embarkation port was he informed that he was to be discharged as LMF. He demanded an interview with the Air Officer Commanding, as he was entitled to do, but the AOC saw him briefly and tersely informed him that there was nothing that he could do. He was returned to a disposal unit in the UK where his rank badges and wings were removed, he was given a khaki uniform and informed that he was now in the army. After basic training with a squad of former RAF or naval men he was returned to Italy as an infantryman and served in that capacity until the end of the war.

Case 2

A mildly obsessional 18 year old man was delighted to be sent to Canada for pilot training. He made good progress despite feeling slightly apprehensive every time he flew alone. On one occasion, while on a cross country solo flight at 6,000 feet, well away from base he decided to try some aerobatics which were strictly against orders. All was going well until he mishandled a manoeuvre and found himself in an inverted spin. He was losing height rapidly and panicked trying actions at

random instead of using the techniques that he had learnt, at least in theory. The inherent stability of the aircraft finally triumphed and he found himself in level flight by which time he was only 200 feet above the ground. He was still trembling when he reached home base , but did not confide in anyone. From this time on , he became increasingly apprehensive before every flight and was at times terrified in the air. After some weeks , he saw his instructor and informed him that he did not think that he was cut out for flying. He was reassured that he was a good average pilot and would gain confidence with more experience. Unwilling to admit that he was afraid he feared the consequences if he asked to be 'washed out.' Later he discovered that it was possible to ask for transfer to another aircrew category without facing disciplinary action and he applied to be a bomb aimer. He completed his training and returned to England to 'crew up' at an Operational Training Unit (OTU). He was soon popular with his crew and they flew together on six operations without any of them being aware of his terror of flying. On the seventh mission he froze shortly after take-off, he was literally scared stiff and unable to talk. They returned to base and an ambulance was waiting to take him to sick bay. There he soon relaxed and when seen by the Medical Officer(MO) nothing abnormal was found. He was taken straight to the Group Captain Commanding the station where he was treated to a verbal assault, in which he was accused of being a coward who had endangered the lives of his crew and was ordered off the base. An apologetic Sergeant Policeman helped him to pack his belongings and he was placed in the rear of a covered truck and driven for half an hour to another RAF unit which he never identified. There, he was seen by another MO who asked him what had happened and over the course of two hours he recounted the full account of the development of his flight phobia. The MO advised him on how to manage his fear then explained what would follow the label of LMF. At the end of the session he was offered the choice of continuing the LMF procedure or returning to his unit and chose the latter. Initially the Station Commander refused to have him back but with the MO's persuasion agreed to do so if his crew were willing to take him back. The pilot was consulted and agreed without hesitation. The bomb aimer returned to the station and was warned by a disgruntled Group Captain that he would be under constant scrutiny and any hint of problems would be severely dealt with. In fact no-one ever mentioned the incident again. He returned before most of the squadron were back from the raid and his crew never spoke of the incident but they maintained their close social life together despite the fact that both the pilot and navigator were soon commissioned. He had also been recommended for a commission but this was squashed by the Station Commander. On the last trip of their tour they crash-landed their badly damaged aircraft on their home base, two of the crew were killed and the bomb aimer suffered moderate burns in attempting to rescue them. The rest of the crew never returned to operational flying for after their rest period the war was coming to an end. Today, nearly 52 years later, he is still afraid of flying , even as a fare paying passenger despite a successful career as a business executive.

Some 100,000 men flew with Bomber Command during the war and 55,573 were killed in action. Overall, between 1939 and 1945, for every 100 aircrew joining a heavy bomber crew in OTU (Messenger, 1984),

51 were killed on operations

- 9 were killed in crashes in England
- 3 were seriously injured in crashes
- 12 became Prisoners of War
- 1 was shot down and evaded capture
- 24 survived 'unharmd', though sometimes wounded

The overall figures for removal from flying duties for other than physical causes were:

Year	Neurosis	LMF
1942-3	2503	416
1943-4	2989	307
1944-5	2910	306
Totals	8402	1029

From the figures reported by the Neuro-psychiatric Division, it is estimated that over 30% of all LMF cases were disposed of purely by executive action, without involving specialist medical referral. Approximately one-third of neurosis cases came from Bomber Command, one-third from Flying Training Command, and one-third from other commands (Air Ministry, 1947). One-third of 1,029 is 343; if in addition 147 were not seen by specialists, this represents 490 in 3 years, i.e. 163 per year or 14 per month. Lawson (1945) suggests that 0.4% of Bomber Command crews (including OTUs) were categorised as LMF in 1944, so that with 50,000 aircrew, the rate was about 200 per year. Thus, a minimum number of 160 per year and a maximum of 240 is the best possible estimate.

Official beliefs about LMF were that:

1. Courage equated with character, and that it was possible to identify and select those with the 'right stuff.'
2. LMF was a dangerously contagious state.
3. The maintenance of morale depended on the early identification and removal of 'waverers'.
4. Disposal of those unwilling to continue operational flying was not a medical decision.
5. Unless rigorous measures were taken, the operational efficiency of Bomber Command would be compromised.

The aircrew selection methods were reasonably successful, but this was within a volunteer group who were above average in intelligence, education, and physical fitness. When selection had to be extended to those who had not been to the 'right' schools nor had distinguished themselves in sports, there is no evidence that there was any lowering of standards or efficiency. In the United States Air Forces, all pilots, navigators, and bomb aimers were commissioned, but the RAF was reluctant to admit those of inferior social status to the status of even 'temporary gentleman', despite the recommendations of Sir Arthur Harris, Commander in Chief of Bomber Command, for much of the war. However, this reluctance became less marked as the war progressed.

No evidence has ever been produced to justify the claim that LMF was contagious. Medical understanding of neurosis was limited during the war. Recent views on PTSD, bereavement, and panic disorder would suggest that many of those labelled LMF would now be regarded as suffering from specific disorders which were not then understood. In fact, Sir Arthur Harris said afterwards that morale was never a problem in Bomber Command (Harris, 1995).

A recent comparative study by Colonel Mark Wells, USAF comprehensively reviews the experience of aircrews of both Air Forces engaged in the Bomber Offensive (Wells, 1995). Despite differences in operational policy and a friendly rivalry which resulted in an assumption by each service that they managed things 'better' than the other, the rate of emotional casualties in the American 8th Air Force was similar to that of Bomber Command.

Wells contrasted the British deterrence-orientated policy, belief that failure in combat originated with flaws in character and that LMF might be contagious, with the American view. This was that predisposition was less important than stress, and that even the best men might eventually suffer the effects of combat stress. With this policy, the emotional stigma of emotional breakdown was largely removed. They were also less likely to believe that emotional disorder should be considered infectious.

Despite inconsistencies in the operation of policies in both Air Forces, the American system was on the whole less punitive. Symonds (1945) was unaware that the RAF and the Eighth Air Force were roughly comparable in their rates of emotional problems and was critical of the American 'openness', which encouraged men to express their fears and 'deal with them.' He believed that the RAF's use of 'pejorative' terms such as 'neurosis', rather than the American 'operational fatigue', minimised the number of casualties. The consequences of 'going LMF' were very much in the mind of British crews, but never figured prominently in the concern of their American counterparts.

Conclusions

The balance of evidence suggests that the use of the LMF label was neither necessary nor effective. However, there remains the question of whether it was humanely applied. Lawson (1945) and Balfour (1973) are representative of those who believed that this policy was fairly applied. Other evidence, though, suggests that it was often unduly harsh and indeed, often did not conform to the policy guidance. It was not intended to apply to men who had completed a full tour, yet some who had been decorated and completed one or even two tours were dealt with as LMF. Sometimes, public humiliation within the unit was part of the treatment (Wainwright, 1978).

None of the men responsible for this policy were inhumane and most had direct experience of combat, though often in the distant past. They were, however, in the upper echelons of command and lacked direct contact with the crews on an informal basis.

The general duties medical officers were not specially equipped to deal with flying stress and were remote from those crew members who were not members of the Officers' Mess. Specialist medical officers with responsibility for final diagnosis were neuropsychiatrists, usually with the emphasis on neurology. It is

interesting to speculate how the situation would now be managed, given current knowledge, but in every conflict, including those recent ones, the lessons of previous wars have had to be relearned.

Given this background, it would be reasonable to suggest that all aircrew should share common messing facilities and have a trained flight medical officer who shares their lives. More important still, however, would be the education of both junior and senior commanders in the prevention and recognition of stress-related behaviour and the provision of facilities for dealing with it. Such arrangements might well prove more successful in conserving valuable manpower resources than the policy just described.

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7 'Though ever the subject of psychological medicine': psychiatrists and the colony solution for mental defectives

MATHEW THOMSON

In 1913, the British Parliament passed the Mental Deficiency Act, which established the legal framework to provide specialised institutional care for those deemed mentally defective.¹ Before 1913, such people had been placed in one of three situations: in asylums under the Lunacy Act, in poor-law workhouses, and a minority in voluntary Idiot Asylums. The 1913 Act envisaged that every county and county borough local authority would ascertain defectives living either in these other institutions or in the community, and would build special institutions to house them. This chapter will consider the part played by sections of the psychiatric profession in the emergence and development of this policy during the 1920s and 1930s.²

In his influential but controversial history of nineteenth-century psychiatry, Andrew Scull argued that the increase in the number of insane in institutions was partly the result of 'professional imperialism'.³ In the case of the development of mental deficiency policy in the early-twentieth century, I will propose that although professional self-interest was a factor in the type of care which emerged, the notion of 'professional imperialism' is too crude an explanatory tool: such a notion assumes that the profession was more coherent and powerful than it actually was (see chapter 12). In fact, it was not always clear what was in the profession's interest, since it was divided into groups with different and sometimes competing interests; moreover its actions were often negated by administrative constraints. The profession's role will be considered here through psychiatrists' attitudes to and activity in the passage of the 1913 Act, the limitations of the profession in developing specialised mental deficiency institutions, and the outcome of these factors on the type of institutional solution which emerged. Underlying this analysis will be a second theme exploring the relationship between administrative constraints, professional interests, and the categorisation of people into different types of care: it will be suggested that the division between mental deficiency and mental illness, made in 1913, was to a certain extent arbitrary, a product of the political, professional, and administrative configurations of that period, and one which became increasingly awkward as professional and administrative interests altered.

I

The historiography on the 1913 Mental Deficiency Act has emphasised its eugenic content and support; it is generally accepted that the Act provides the major example of such ideas influencing British social policy. I have argued elsewhere that this is too narrow an interpretation – eugenics was an important influence, but there was a series of additional rationales to justify the Act.⁴ An important influence on the legislation were the views of psychiatrists.

The closest we have to a voice of the British psychiatric profession during this period was the *Journal of Mental Science (JMS)*, the official organ of the Medico-Psychological Association (MPA). In the first two decades of the century, its opinion was generally favourable towards separating mental deficiency from mental illness. The MPA actively lobbied the government to act upon the 1908 Report of the Royal Commission on the Care & Control of the Feeble-Minded, and was in close contact with Home Secretary, who was Reginald McKenna, when the Bill was under consideration.⁵

An indication that eugenics was not the primary concern of the profession is that the *JMS* reported favourably on the amendment of the controversial eugenic clause of the Bill, which had originally recommended institutional care for cases if 'it was desirable that, in the interests of the community, they should be deprived of the opportunity of procreating children', to the less contentious, 'those who are in receipt of poor relief at the time of giving birth to an illegitimate child or when pregnant of such child'.⁶ The MPA also had other concerns over the original Bill: it played a role in altering the definition of mental deficiency from 'mentally infirm persons, that is to say, persons who through mental infirmity arising from age or decay of their faculties, are incapable of managing their affairs or those of others,' to the more restrictive 'from birth or early age'. The former definition would have included the senile, who were an increasing concern at the time and blamed for the escalation of asylum populations, but whose 'inclusion would have upset arrangement in all the asylums'.⁷ The MPA also expressed concern over the creation of a new government department, the Board of Control, to administer mental deficiency, and was relieved when it took on the old Commissioners in Lunacy as its staff, instead of 'amateurs': therefore, 'it would be administered with sound common-sense, and by men who were trained and experienced'.⁸ In 1914, as the local administration of the Act began to develop, the *JMS* again favoured continuity, proposing that mental deficiency work be taken on by the extant asylum visiting committees.

A common thread links these views of the MPA: (a) a desire for reform, but reform which did not too greatly disrupt the status quo; (b) the Mental Deficiency Bill had to be sanitised of overt eugenic language, so that it did not stigmatise the work of psychiatrists; (c) the separation of defectives from the mentally ill was not to disrupt mental hospitals and was to be implemented on medical criteria (thus protecting psychiatrists' roles) rather than manageability; and (d) administration of the new Act was to remain in the hands of those civil servants who had already forged close links with the psychiatric profession. In summary, the MPA was protecting the interests of the existing lunacy management system.

If the MPA was largely motivated by protection of the status quo, why should it have supported the Mental Deficiency Act at all? Though an explanation will be presented here, at the same time it will be suggested that a tension did exist

over whether the Act was in the whole profession's self interest – a tension which can help to elucidate a number of the problems which subsequently emerged. Some specialisation of mental deficiency care had already taken place since the mid-nineteenth century, with the development of a number of both voluntary and private asylums for idiots, as well as homes for the feeble-minded (less handicapped than idiots) around 1900. Therefore, the principle of dividing off the mentally defective had already been largely accepted. However, the Report of the Royal Commission on the Feeble-Minded made it clear that only a minority of this group were being catered for, and that a new solution had to be found;⁹ psychiatrists serving as medical superintendents of existing idiot or feeble-minded homes had been influential witnesses. The Commission was particularly impressed with the idea of the colony, which would provide mass accommodation, cheaply built and run. The colony was idealised as bringing defectives the therapeutic benefits of fresh air and country life, with education, training, and employment to divert them from misbehaviour, and a community atmosphere to socialise them. It was also attractive as a policy solution which was currently being applied to other problems such as unemployment, inebriacy, and epilepsy.¹⁰ Psychiatric witnesses favoured colonies of mixed types of defectives, arguing that the more able patients could help with the running of the colony and caring for less able patients.¹¹ The Commission also rejected the model developed in London by the Metropolitan Asylums Board (MAB) of large colonies under the Poor Law, specialised according to the grade of defective.¹²

The choice of mixed institutions, and the stress of the Report on detecting different types of defective, justified medical control of these institutions. Faced with the proposal that a system of specialised institutions should be created for mental defectives, and agreement with this from those psychiatrists already working in this field, it is unsurprising that the MPA gave its support; the alternative could have been the specialisation of the Poor Law (as under the MAB in London) and development of a system of care under lay managers. Since the prestige of the profession was generally very low, support of the 1913 Act can be seen as one of a group of strategies to enhance its status, including the Asylum Officers' Superannuation Act of 1909,¹³ the introduction of a new psychiatric diploma in 1910 (see chapter 12), and the ongoing campaign to liberalise the rigid legalism of the 1890 Lunacy Act so that it would be possible to treat patients while still curable, before they had deteriorated to be certifiable.¹⁴ The new mental deficiency system promised professional opportunities for the expanding membership of the MPA, and associated the psychiatric profession with the progressive aura which surrounded the 1913 Act. In summary, for the profession, the 1913 Act symbolised an agenda of which care for defectives itself was only a part: specialisation of care would open up new opportunities for it; the colony provided a new set of rationales for medical superintendence; and the new Board of Control would represent the views of psychiatry within central government, as well as stimulating research and medical science.

II

The optimistic aims of 1913 fell far short of their targets over the next 30 years. It had been hoped that the Board would be:

an active and efficient centre, both for the general protection and supervision of the mad, and also, for the promotion of measures of scientific administration and investigation, which will prevent, as far as may be, the increase of mental disease and defectiveness.¹⁵

Although the position of the Commissioners in Lunacy and the representation of psychiatrists as Commissioners had been preserved on the new Board of Control, and the Board had been given greater powers than the old Commissioners, the influence of psychiatrists within central government gradually diminished during the inter-war period.¹⁶ Even during the passage of the Mental Deficiency Act, there had been parliamentary and public objections to the increased power of non-elected experts within government.¹⁷ The title 'Board of Control', intended as a less emotive and stigmatised title than 'Commissioners in Lunacy' – with all its nineteenth-century associations – was perhaps an unfortunate choice; the Board was soon caricatured as the monstrous Board of Control whose 'controlling' tentacles reached out to snatch innocent children.¹⁸ Its character was unsuited to the dominant culture of the inter-war civil service; the Board had been created just as the vogue for expertise and efficiency in government peaked. The specialisation of government proposed by the Minority Report of the Royal Commission on the Poor Law and then the Haldane Committee was not carried through. Instead, during the inter-war years, the civil service became dominated by the idea of the administrative expert – the figure who was skilled in methods of administration and could move from department to department.¹⁹ The Treasury, which developed this model, looked unfavourably on civil servants becoming tied to one department, as this was considered likely to create loyalties and destroy objectivity.

The Board of Control was originally given direct control over a budget to stimulate psychiatric research, and between 1914 and 1920, its record for guiding research was impressive. This was seen as contributing to a solution to the medical problems of mental illness and deficiency and as encouraging more able candidates to enter the profession.²⁰ But once the Medical Research Council was created, the Board lost this independent role,²¹ and since psychiatric questions had a low priority at the MRC, government support for research at mental institutions then virtually disappeared.²²

The Board's independence was further threatened in 1919 with the creation of the Ministry of Health. The Commissioners were anxious to maintain their long administrative tradition, but realised that if they remained outside the new Ministry, this would perpetuate the stigma of mental illness. Through stressing their unique combination of psychiatric and legal expertise, the Commissioners maintained their separate status as a Board within the Ministry,²³ but it was difficult to escape interference, especially as the Ministry viewed the Board and the mental hospital system as a whole with a degree of suspicion. In 1922, its influential Chief Medical Officer, George Newman, described the lunacy and mental deficiency systems as a 'serious blot in our public health system', and saw it as an area ripe for reform:

The problem of mental disease should now be dealt with on the broad lines of preventive medicine and remain no longer a sort of early Victorian cul de sac of hopelessness and *laissez faire*.²⁴

However, the care of the mentally ill and particularly of the defective was a low priority, when placed alongside the Ministry's expanding commitment to the general health care of the public. As Newman admitted:

I must make it clear that I am considering the whole of the lunacy issue (like the milk problem) from the point of money. If times were normal I should venture to advance definite progress all round – but I find it very difficult to see how we can advance with public opinion unfavourable to extensions and without money.²⁵

It is indicative of the Board's status that in discussions over the introduction of voluntary treatment for the mentally ill, there was considerable doubt as to whether it would be publicly acceptable to place this under the stigmatised Board.²⁶ Over the course of time, the Ministry gained greater influence over the Board by the successive appointment of its own men as Chairmen. The first Chairman, W.P. Byrne, who had a background in the Home Office, seems to have come into conflict with the administrators at both the Board of Education and Ministry of Health. He was replaced by F.W. Willis who had served in the Local Government Board and the National Insurance Commission, both progenitors of the Ministry of Health. In describing the necessary qualities for the Chairman, Alfred Mond, Minister of Health, pointed to the advantages of administrators rather than professional experts:

The main qualifications for the post are those of an experienced administrator capable of managing a comparatively small but still important department of the state, well and economically.²⁷

The trend towards administrative control continued as Willis was succeeded by Laurence Brock, a protégé of Sir Robert Morant, who inherited his mentor's desire to integrate mental health into the mainstream of public health and for government to be in the hands of an administrative elite.²⁸

However, probably the greatest limitation on the Board came from the Treasury, either directly, or through the conduit of Ministry of Health control. Not only did the Treasury constrain the funding of mental deficiency, but it also undermined the influence of psychiatrists, through its control over civil service appointments.²⁹ Treasury officials viewed the Board as a spendthrift body in which outsiders, such as psychiatrists, had a dangerous influence. To remedy this, the Treasury reorganised the Board of Control to consist of a smaller, centrally located Board, closely monitored by the Treasury and the Ministry of Health, and a second rank of Commissioners and Inspectors who would inspect, rather than develop policy.³⁰ The Treasury objected to paying salaries of a scale necessary to attract psychiatric superintendents to these posts, and even though the Board was so seriously understaffed as to have difficulty in performing its duties, staffing cuts were urged.³¹ Money was saved by replacing Commissioners with the inferior rank of Inspectors, appointing women inspectors on a lower pay scale, coopting voluntary members, and using the appointments to pension off civil servants.³² The dilution of psychiatric influence at the Board, and the erosion of status of Commissioners obviously upset the psychiatric profession, which had come to see these appointments as a form of promotion after a notable career in superintendence.³³ The more centralised structure of the Board also upset psychiatric Commissioners, who valued its function as an intermediary channel for ideas to flow between the profession and government.³⁴ Tensions between

the Board and the profession continued for some years, the MPA proposing in 1937:

That a protest be made by the Association as to the present constitution of the Board of Control, especially as to the fact that there are few members who are experienced in the treatment of mental disorder and the management of mental hospitals; and also pointing out that there is no representative of the consulting staffs of general hospitals on the Board. We consider that the emoluments offered are quite inadequate for the responsibilities of the position.³⁵

Ironically, the weakness of the Board, in particular its limited staff, meant that there was little interference with psychiatric superintendents in the running of institutions; the Board had to rely on medical opinion on the spot, however unreliable, or otherwise the system of administration would have collapsed.³⁶

The dilution of psychiatric influence at the Board lessened the chances of protecting the mental hospital and deficiency systems in an era of draconian expenditure cuts.³⁷ Within the parsimonious environment of the inter-war civil service, the Board was forced to accept an erosion, or at least a lack of substantial improvement of standards in colony care, and had to convince the profession to accept this. The idealistic vision of the colony which had evolved in the first decade of the century was extremely difficult to realise in the economic environment of inter-war Britain. As early as 1919, the Board of Control sent a circular to all local authorities urging economic adaptations of the colony model.³⁸ Also, despite the aim for specialised care, the Board accepted the role of poor law institutions as providers of specialised care, under Section 37 of the 1913 Act. The power of the Board to approve building plans was soon being used to pare down, rather than raise standards. Coming under pressure from the Treasury over the cost of care per patient in mental deficiency hospitals, the Board defended this by arguing that mental deficiency institutions, as sites of permanent segregation, had to provide more for residents than mental hospitals; moreover, the colony was quite inexpensive if compared to the total cost of prisons, police activity, and workhouse accommodation, which, it was argued, was the alternative for defectives left in the community. Therefore, to avoid or delay building mental deficiency institutions would prove a 'false economy'. The Treasury accepted this argument, but in return, the Board became committed to keeping the cost of the colonies down to a minimum.³⁹

Objections to the cost of mental deficiency institutions continued throughout the 1920s. Local authorities complained to the Treasury that the Board was exercising them, arguing that they already had mental hospitals and that the size of the ascertained defective population did not justify specialised separate care. The Ministry of Health became concerned when the cost of a proposed institution, at £320,000 for 1,000 patients, was the equivalent of £1,500 for a five-person home more than that spent by the Ministry in building working-class housing.⁴⁰ On the other hand, the Chairman of the Board also seems to have been under pressure to satisfy his psychiatric Commissioners, who were concerned about erosion of standards.⁴¹ As a result of such concerns, the Hedley Departmental Committee was set up to consider whether the costs of building and running colonies could be reduced even further; its members were carefully chosen to make sure that while the recommendations would be penny-pinching,

they would also satisfy the doctors, as far as possible.⁴² They included an architect, Sir George Oatley, who had built inexpensive villas in colonies, Dr Rotherham, a Commissioner and former superintendent 'a rigid economist', and Dr Douglas Turner, Medical Superintendent of the Royal Eastern Counties Institution, who, as the son of the previous superintendent, was said to have been 'born in a mental deficiency institution and has literally spent his whole life in them.'⁴³ With such a Committee, it was unlikely that there would be criticism that colony standards were too low: it supported the model of colonies of mixed grades, internally divided into specialised villas, and headed by a medical superintendent. Separate 'villas' of about 60 patients each were recommended for high-, medium- and low-grade defectives, with further subdivisions to segregate the sexes, adults and children, and troublesome defectives. This high degree of internal specialisation led to the recommendation of far larger institutions than had been envisaged in 1908, with an optimum size of 1,000-1,500 residents. The argument that this was too large for the development of a community spirit was discounted on the grounds that the villa was the key in providing this. Worryingly for medical superintendents, it was acknowledged that this scale would be too large for individual contact with patients, but this was considered only of secondary importance to cost. The Report made it clear that the organisation of defectives in work was the main function of colony management: 'It is the aim at every colony to employ, and employ usefully, as many patients as can be taught to do some work.'⁴⁴ Whilst economy vied with standards of care throughout the Report, the former usually prevailed. This was notably evident in the recommendation for squeezing defectives into wards with three, rather than two rows of beds across. Acknowledging the spartan style of its proposals, the Report argued that: 'the mentality of its inmates will, in the main be too undeveloped to appreciate the finer distinctions which would trouble the normal intelligence.'⁴⁵ However, despite all these economies, the Committee were only able to reduce the cost of building per bed to £300. Having defended the colony against charges of profligacy, the Hedley Report did not in fact provide a drastically cheaper solution. The model which emerged confirmed the development of mental deficiency institutions into massive organisations with a range of needs, from care for severely handicapped defectives, to management of high-grade defectives in industrial employment. Finally, the economies recommended by the Hedley Committee further exacerbated relations between the psychiatrists on the Board, vainly trying to preserve standards, and lay civil servants.⁴⁶

The vision of 1913 was also eroded by developments from within the profession; in the first decade of the century, mental deficiency work had seemed an outlet for expansion, but conditions changed rapidly and it remained a professional backwater.⁴⁷ Through war fatalities and retirements, the First World War lowered the membership of the MPA, from 747 in 1913 to 661 in 1919, removing the surplus in the profession which previously had encouraged a search for new outlets.⁴⁸ The wartime 'shell-shock' problem raised optimism about the ability to cure milder forms of mental illness through psychotherapeutic approaches, but this had little impact on treating the severely ill within mental institutions.⁴⁹ The MPA tried to remedy the poor reputation of institutional psychiatry by emphasising the importance of education and psychiatric training, as well as by publishing more scientific literature in the *JMS*. However, these developments did not favour mental deficiency since the

new courses, such as that at the Maudsley Hospital, contained little on it, and the enthusiasm for any new therapeutic approaches was directed at the mentally ill rather than defective.

With the passage of the 1930 Mental Treatment Act, which legislated for voluntary and temporary treatment of the mentally ill, the prospects for their early and successful treatment were improved. By contrast, mental deficiency work offered few rewards; apart from the recognition and classification of defectives and general medical care, psychiatrists could not claim to perform an essential medical role. Talented young doctors were therefore unlikely to enter this field, especially since the payment and conditions of work for junior medical officers were so poor. Indicative of the low status of this work, members of the MPA involved in mental deficiency were generally less well qualified than those in mental hospitals, etc.

A survey of RMPA members in 1937 shows that of those involved in mental deficiency (through research, membership of committees, or employment) only 35.8% had special psychiatric qualifications, compared to a rate of 48.1% for the rest of the profession. Those involved in mental deficiency also had a low number of members involved in committee work. Notably, it was those doctors who wrote about mental deficiency and ran private homes, but did not work in mental deficiency colonies, who gained professional recognition by membership of the Royal Colleges. The exception to the low status of the mental deficiency superintendents was Douglas Turner (significantly a great advocate of the colony solution), who was made President of the RMPA in 1933.⁵⁰ The Board of Control constantly complained about the problems of finding qualified psychiatrists to serve as superintendents for these institutions. Indeed, in 1937, of the certified and state institutions, only 23 were under a medical head; doctors also ran 5 large voluntary institutions, but there were 103 others (many of them small and privately or voluntarily funded) that were run by lay persons.⁵¹ Internal developments of the profession were also unfavourable to attempts to remedy limitations to the colony solution. Whereas in 1913 the MPA had openly lobbied government, it avoided such overt political roles in the inter-war years.⁵² For instance, it took a cautious position in the campaign for the Mental Treatment Act.⁵³ Politics was not seen as the appropriate role for a profession desperate for medical respectability – which was signified by becoming the Royal Medico-Psychological Association in 1926.

The prospect for psychiatrists in mental deficiency institutions was therefore fairly bleak in the early 1930s, and this led to a defensiveness against the rest of the profession. For instance, E.J. Fitzgerald, Medical Superintendent of the Bridge Home Essex, opposed proposals to combine the administration of mental deficiency with mental illness at the local level, complaining that mental hospital superintendents,

tended to look down professionally on the mental deficiency people. Those who entered upon mental deficiency work were often regarded as those who had gone into a sterile world, where there was little to be done on the lines of preventive medicine.

Equally, Fitzgerald criticised the way that methods of occupational therapy, developed in mental deficiency, were being appropriated and misapplied in mental hospitals.⁵⁴

One strategy to counter the low status of mental deficiency work was the establishment of a Mental Deficiency Sub-Committee within the RMPA.⁵⁵ However, it was difficult to avoid the problem of the non-therapeutic basis to colony care. As Thomas Lindsay acknowledged, 'In some patients all that seems possible is an attempt to improve their habits, and make them less of a burden to themselves and those who look after them.'⁵⁶ Nevertheless, in the 1930s, there was an attempt to develop medical science within these institutions, and some of this work, such as investigations into the inheritance of mental deficiency, was directly targetted at prevention of mental deficiency. Much of it simply used the controlled environment and passive population of the colony to test out general medical therapies, such as vaccines, or experimented in the use of techniques such as the Wasserman test, and was of little direct benefit to the welfare of the defectives.⁵⁷ R.M. Stewart, Medical Superintendent of Leavesden Institution, saw opportunities in the classification of types of mental deficiency: 'To the student of mental deficiency the lower grade of oligophrenia offers endless opportunities for the exercise of medical acumen, and in this largely unexplored terrain there are doubtless many syndromes awaiting discovery.'⁵⁸

III

A further problem for the colony vision of 1913 involved the division which had been made between mental deficiency and illness. There had always been a danger that to alleviate the pressure on mental hospitals, mental deficiency would simply become a dumping ground for the incurable and difficult. A reviewer in the *JMS* prophesised in 1920:

Time alone will show whether ultimately it [mental deficiency work] will overshadow lunacy, but there is no doubt that activity in this direction will lessen lunacy operations, especially as regards the chronic insane. The time may come when lunacy under a more appropriate name will be largely a routine hospital matter like other diseases, the residuum insane being housed in suitable homes, and with the degenerate, mental deficient and criminal ceasing administratively to be primarily of medical concern, though ever the subject of psychological medicine.⁵⁹

Although the 1913 Act partly arose out of the problem of a rising population in mental hospitals, and there had then been pressure to deal with the senile along with the defective, the psychiatric profession had preferred a model of specialisation of care. The issue of how to divide sectors of care re-emerged in the inter-war period, when low institutional death rates led to the problem of a growing population of incurable, chronic, and senile patients in mental hospitals. Concern about overcrowding increased with the the Mental Treatment Act of 1930, since it was felt that this would encourage far more patients to come forward for treatment. Pressure from a second direction came with the publication of the Interdepartmental (Wood) Committee on Mental Deficiency, which inflated the estimate of the number of defectives needing institutional care.⁶⁰ The issue was further complicated by plans, in the early 1930s, to abolish the Poor Law system, raising the question of what to do about the considerable number of uncertified mentally ill and defective who were still

resident in workhouses. The resources of psychiatry were not adequate to cope with current demands, let alone the expansion which seemed imminent.

The prospect of a rapid increase in demand for hospital space provoked consideration of a reordering of the mental care system. One suggestion was to have one set of institutions for the curable who needed psychiatric therapy, another for those who simply needed care, and another for those who needed custody but could function as working colonists; in 1930, the Board published a circular which suggested using old Poor Law accommodation to transfer 'those of the elderly and unemployable types' from mental deficiency institutions.⁶¹ There was also consideration of transferring some of the chronic and senile patients from mental hospitals into mental deficiency institutions – the Wood Report had suggested that about 18% of the mental hospital population were in fact also mentally defective. The Board of Control set up an investigation under its Drs Wilson and Lewis to investigate this possibility between 1932-3.⁶² They surveyed the populations of 11 mental illness hospitals, with nearly 12,000 patients, and confirmed that 14% were defectives. It was recommended that those under 30 years of age should be sent to a colony (as fit workers), those over 40 to one of the public assistance institutions (as the poor law institutions had been renamed), while those between 30 and 40 should go to a colony only if they were in good physical condition. So called 'cot and chair' defectives should also be sent to a colony, since they were in need of special care. Although it was felt that actively psychotic defectives should be kept in mental hospitals, the investigators pointed out that, 'This [psychotic] is a wide net, and sweeps in a great number who are not noticeably different from the ordinary population of Mental Deficiency Institutions.' If these proposals had been acted on, it would have removed about 15,000 patients from the country's mental hospitals. Yet the investigators hinted at an even more fundamental reorganisation of types of patients, pointing out the similarities between mental deficiency and certain forms of mental illness:

the relation between defect and schizophrenia proved to be interesting, both from the admixture of symptoms in some cases, and the apparently very early onset of schizophrenia in other cases, so that a condition was produced which from a legal or even the medical point of view might be called defect.⁶³

They also pointed out that the problem of violence was often not due to mental illness, but was simply a product of defect; mental defectives were often violent for pleasure, not realising that they were doing wrong. The investigators viewed sexual perversions, in which they included homosexual activity, in the same way. They concluded that the majority of the violent should be placed in mental deficiency institutions and reformed by training and good management in the colony.⁶⁴

If a rearrangement of the administrative divide between mental deficiency and illness had taken place it would have strengthened the suspicions of lay critics that the care of mental defectives was a managerial rather than a psychiatric issue, and thus better performed by lay managers, who would be more effective at keeping costs low. However, because of the legal distinction made in 1913, rearrangement was very difficult. As Brock, Chairman of the Board, recognised, there was also a series of 'insuperable' practical problems associated with any such reorganisation

of the administrative division between mental deficiency and mental illness. In the case of high-grade defectives in mental hospitals, 'if the patient is useful the mental hospital will not give him up, and if he is a nuisance the colony will probably find some excuse for sending him back'; while transfer of low-grade cases was 'likely to necessitate a disproportionate increase in the nursing staff, and it will tend still further to increase the already high maintenance rate in many newer colonies.'⁶⁵

As it turned out, the expected increased burden did not fully materialise: the Poor Law, though abolished in name, lingered on in the form of Public Assistance Institutions; the number of patients treated in mental hospitals under voluntary and temporary orders was not as high as expected; and the mental deficiency system never catered for the numbers detected by the Wood investigation. Nevertheless, numbers continued to rise and, with resources restricted in the financial crisis of the Depression, there were calls for alternatives such as voluntary sterilisation of mental defectives and use of licensing in the community. However, among members of the RMPA, particularly those involved in the care of defectives, these were not seen as practical alternatives. This is hardly surprising if one considers professional interests; such policies were rather viewed as supplements, extending the reach of the colony into the community. Turner epitomised this view:

The institution would be a flowing lake, always taking in, always sending out, but sending out only – and this is a most important point – to other smaller lakes, each of which shall feed from it.⁶⁶

He doubted whether sterilisation could alleviate the demands on the institutional system; in his view, it was pointless, since the vast majority of defectives still needed institutional care or close supervision on licence. It is perhaps no coincidence that Turner was President of the RMPA in 1933, when it chose to withhold public support for sterilisation, despite majority support in two internal surveys.⁶⁷

IV

In 1913, the official voice of the psychiatric profession, the MPA, had viewed the Mental Deficiency Act as providing great opportunities. However, after 20 years of development, E.A. Doll, the American mental deficiency expert, produced a damning assessment of the system which had evolved:

I sensed an atmosphere of conservative administrative policy, apparently reflecting traditional social attitudes . . . practice lags behind ideas and a conventional inertia cools the ardour of enthusiastic novitiates.⁶⁸

This chapter has attempted to explain how the idealistic visions of the colony in 1913 resulted in the situation described by Doll. In order to defend their control over mental deficiency, and to satisfy demands for efficiency, psychiatric superintendents became managers who gave greater priority to economy than to therapy and standards of care. As such, professional self-interest was one factor

in the evolution and stagnation of the colony system. However, we also need to take into account the problems caused by the process of professionalisation: because therapeutic prospects in mental deficiency institutions were so limited, the work was of low status within the psychiatric, and even more so the broader medical profession, and therefore it attracted weaker candidates and tended to be neglected by the profession as a whole. By the 1930s, the administrative inertia of central and more especially local government, together with pressure to economise made reform unlikely: the cost-cutting colony solution, despite all its problems, had become institutionalised.⁶⁹

Notes

- 1 For elaboration of the ideas developed in this essay see, M.P. Thomson, 'The Problem of Mental Deficiency in England & Wales, c. 1913-1946', (D.Phil., Oxford, 1992).
- 2 Although the term 'profession' is used, the analysis will concentrate on those psychiatrists involved in institutional psychiatry, rather than the growing body of psychiatrists outside institutions.
- 3 Andrew Scull, *Museums of Madness: the Social Organisation of Insanity in Nineteenth-Century England* (London, 1979). More generally, professional legitimation has been depicted as lying at the centre of the expansion of medical care. The problem with such an approach is that it rests on the notion that professions are united bodies, defined according to an ideal type of 'profession'. It is misleading, though, to define the psychiatric profession too tightly, since it was evolving and multi faceted. Therefore, in this essay, I shall follow recent sociological work which calls for a shift in interest from defining professional identity to studying professionalisation as an ongoing and complex process: E. Friedson, 'The Theory of the Professions: the State of the Art', in R. Dingwall (ed.), *The Sociology of the Professions* (London, 1983), pp. 19-37.
- 4 Thomson, M. (1992) *The Problem of Mental Deficiency in England & Wales, c. 1913-1946* (D.Phil. thesis, Oxford University) pp.11-48.
- 5 PRO MH 58/97.
- 6 Notes & News, *JMS* (1913) p. 146.
- 7 Review of Board of Control Annual Report, *Journal of Mental Science* (1920), 66, 289.
- 8 *Ibid.*, 146; *JMS*, 58 (1912), p. 563.
- 9 *Report of the Royal Commission on the Care and Control of the Feeble-Minded* (PP, Cmnd. 4215-21, Vols xxiv-xxxix, 1908).
- 10 On the idea of the colony, see, M. Thomson, 'Sterilisation, Segregation, and Community Care: Ideology and Solutions to the Problem of Mental Deficiency in Inter-War Britain', *History of Psychiatry*, iii (1992), 478-88.
- 11 F.W. Mott, *Royal Commission on the Care and Control of the Feeble-Minded*, Vol. I pp. 8015-93.
- 12 M. Thomson, 'Social Policy and the Management of the Problem of Mental Deficiency in Inter-War London', *London Journal*, 18 (1993), 129-42.
- 13 Asylum Officers' Superannuation Act,
- 14 C. Unsworth, *The Politics of Mental Health Legislation* (Oxford, 1986), pp. 119-27.
- 15 *Report of the Royal Commission on the Care & Control of the Feeble-Minded*, Vol.VIII, (1908), p. 280.
- 16 For a more detailed discussion, see M. Thomson, 'Problem of Mental Deficiency', ch. 2. On the Commissioners in Lunacy see: D.J. Mellett, 'Bureaucracy and Mental Illness: the Commissioners in Lunacy, 1845-90', *Medical History*, 25 (1981), 221-50.
- 17 E.J. Larson, 'The Rhetoric of Eugenics: Expert Authority and the Mental Deficiency Bill', *British Journal for the History of Science*, 24 (1991), 45-60.
- 18 *John Bull*, 17 Oct. 1925; *John Bull*, 3 Sept. 1932.
- 19 H.E. Dale, *The Higher Civil Service of Great Britain* (Oxford, 1941).
- 20 Public Records Office, Kew (PRO), Ministry of Health Files (MH) 51/78; MH 51/80.
- 21 PRO MH 51/85, Fletcher to Board of Control, 26 Feb. 1915, pp. 3-4; J. Austoker, 'Walter Morley Fletcher and the origins of a basic biomedical research policy', in J. Austoker and L. Bryder (eds.), *Historical Perspectives on the MRC* (Oxford, 1989), p. 25.
- 22 L. Bryder, 'Public health and the MRC' in *Historical Perspectives*, p. 69; A. Landsborough Thomson, *Half a Century of Medical Research*, Vol II (London, 1975), pp. 27-8.

- 23 PRO MH 51/631, 'Coordination of procedure with Ministry of Health', c. 1918, and letter to S.W. Harris, 16 July 1918; Addison papers, Bodleian Library, Oxford, Box 39, Byrne, 12 Mar. 1919.
- 24 PRO MH 58/90, Newman to Robinson, 17 Feb. 1922, p. 1.
- 25 PRO MH 58/90, Newman to Robinson, 17 Feb. 1922, p. 5.
- 26 PRO MH 58/90, Robinson, 21 Feb. 1923.
- 27 PRO MH 107/28, Mond to Lloyd George, 21 June 1923.
- 28 V. Markham, 'Sir Robert Morant – Some Personal Reminiscences', *Public Administration*, **28** (1950), 257; PRO MH 107/4; also for Brock see, *Eugenics Review*, **41** (1949), 67, 87.
- 29 G.C. Peden, 'The Treasury as the Central Department of Government, 1914-1939', *Public Administration*, **61** (1983), 371-85.
- 30 PRO MH 58/90, Robinson, 15 Mar. 1923.
- 31 PRO MH 58/90, Grigg, 10 Mar. 1923.
- 32 PRO MH 51/677.
- 33 PRO MH 51/516, E.J. Fitzgerald to Sir Robert Young, 15 Feb. 1931.
- 34 PRO MH 58/96.
- 35 *JMS Supplement*, March 1937, p. 2.
- 36 On the acceptance of medical opinion on the spot, despite doubts as to its accuracy: PRO MH 51/470.
- 37 The major Treasury assaults came in the early 1920s and early 1930s. The Board was reasonably successful in defending current levels of expenditure, but mainly because these were so low already: Thomson, 'Problem of Mental Deficiency', pp. 58-69.
- 38 PRO MH 51/239 Circulars 557 and 557a, 8 Dec. 1919.
- 39 PRO Treasury files, 161 149/13551, J.B. Beresford to Phillips, 21 Nov. 1921, and Edward Troup, 8 Dec. 1921.
- 40 PRO MH 51/710, Robinson to Brock, 3 July 1929.
- 41 PRO MH 58/97, Brock to Robinson, 18 July 1929.
- 42 PRO MH 511710, Brock to Oatley, 8 Jan. 1930.
- 43 PRO MH 58/97, Brock to Hedley, 4 Nov. 1929.
- 44 *Colonies for Mental Defectives: Report of the Departmental Committee (Hedley Report)* (London, 1931), p. 34.
- 45 *Colonies for Mental Defectives*, p. 20.
- 46 PRO MH 58/97, Newman, 11 June 1931.
- 47 For a more detailed discussion see, Thomson, 'Problem of Mental Deficiency', pp. 87-95.
- 48 For membership details see, *JMS*, **23** (1937), xxii-xliv.
- 49 A. Walk, 'The Royal College of Psychiatrists', *St Bartholomew's Hospital Journal*, **77** (1973), 132.
- 50 D. Turner, 'Forty Years in an Institution', *Mental Health*, **6** (1946), 1-5. For details on the construction of this prosopographical analysis see, Thomson, 'Problem of Mental Deficiency', pp. 91-5.
- 51 For a full quantitative analysis of institutional care see Thomson, 'Problem of Mental Deficiency', pp. 95-103.
- 52 A.W. Pierce, *JMS*, **81** (1935), 729.
- 53 C. Unsworth, *The Politics of Mental Health Legislation* (Oxford, 1986), pp. 205-15.
- 54 *JMS*, **81**, **9** (1935), p. 731.
- 55 K Day & J. Jancar, 'Mental Handicap and the Royal Medico-Psychological Association: A Historical Association, 1841-1991', in G. Berrios & H. Freeman (eds.), *150 Years of British Psychiatry* (London, 1991).
- 56 T. Lindsay, 'Mental Deficiency Practice at Caterham Mental Deficiency Hospital', *JMS*, **80**, 398.
- 57 K.C.L. Paddle, 'The Control of Dysentery by Prophylactic Innoculation', *JMS*, **84** (1938), 134-9; T. Lindsay, 'Mental Deficiency Practice at Caterham', *JMS*, **80** (1934), 402-8; K.C.L. Paddle, 'Lumbar Puncture and the Cerebro-Spinal Fluid in 2,000 Cases of Mental Deficiency', *JMS*, **80** (1934), 674-80. For contemporary criticism of this type of work see: H. Yellowlees, 'Modern Psychiatry and Mental Hospitals', *JMS*, **81** (1935), 250-5.
- 58 R.M. Stewart, 'Congenital Ichthyosis, Idiocy, Infantilism and Epilepsy', *JMS* **85** (1939), 256.
- 59 Review of Board of Control Annual Report, *Journal of Mental Science*, **66** (1920), 289.
- 60 *Report of the Interdepartmental Committee on Mental Deficiency, 1925-29 (Wood Report)* 3 Vols, 4 parts (1929).
- 61 PRO MH 58/97, 'Further review of suggestions as to arrangement of colonies for mental defectives' Feb. 1930.
- 62 PRO MH 51/451, 'Mental defectives in mental hospitals – Report of an investigation by

Drs Lewis and Wilson, 1932-3, p. 21.

63 *Ibid.*, p. 26.

64 *Ibid.*, pp. 27-34. For a discussion of transfer of patients between poor law, mental hospital and mental deficiency care in London see, Mathew Thomson, 'Social Policy and the Management of the Problem of Mental Deficiency in Inter-War London', *London Journal*, 18 (1993), 129-43.

65 PRO MH 51/234, Brock, 9 July 1934.

66 F.D. Turner, 'Aims of a Mental Deficiency Institution', *Journal of Mental Science*, 74 (1928), 469.

67 *JMS*, 80 (1934), 759-72; *JMS Supplement*, 82 (1936); Thomson, 'Problem of Mental Deficiency', pp. 167-8.

68 E.A. Doll, 'Impressions of Mental Deficiency Work in England', *Mental Welfare*, 15 (1934), 18.

69 For a discussion of the impact of central and local government see: Thomson, 'Problem of Mental Deficiency', chapters 2 & 6.

8 James Crichton-Browne and the Anti-Psychoanalysts

TREVOR TURNER

Looking back, in an article written in 1975 in the *Contemporary Review*, Eliot Slater recalled that 'few if any general practitioners had any idea how to handle neurotic patients, let alone the psychotic ones' (Slater, 1975). He went on to describe how consultant neurologists (*not* psychiatrists) 'monopolised the large and lucrative practice to be derived from neurotic and mentally disturbed patients. To be sure, they had no understanding of anxiety states and depressive illnesses, let alone of schizophrenia, but they did not think it was at all necessary'. It seems that having carried out a careful physical examination to exclude organic disease and having then diagnosed 'neurasthenia' or 'hysteria', they would despatch the patient to the general practitioner for bromide therapy. But this retrospective portrait, from a practitioner steeped in the materialist tradition of Henry Maudsley, misses several key points. Firstly, since the 1930 Mental Treatment Act, outpatient attendance and voluntary treatment – comprising over 35% of all admissions by 1938 (Jones, 1993) – were on the rise. In addition the claims of psychoanalysis had infiltrated both the public (Rapp, 1988) and professional versions of what psychiatry was about, a process admirably reviewed by Malcolm Pines (1991). Although controversial, psychoanalysis and the trinity of Sigmund Freud, C.G. Jung, and Alfred Adler was apparently in the ascendant. Thus, Bernard Hart could claim (Hart, 1931) that Freud had 'advanced psychology to the level of a science', and that this was 'an epoch-making step', since 'his method has indubitably achieved greater success than any other so far as psychoneuroses are concerned and perhaps not much less success in the sphere of the psychoses'. Which is not surprising, given the public tendency to cynicism, as characterised by the views of a certain Judge Tebbs, who remarked, as reported in the Medico-Legal section of the *British Medical Journal* in 1932 (Vol.2, p.1129), that 'he had yet to be convinced there was any such thing as neurasthenia. Apparently when a doctor could not find any specific cause for a patient's illness it was put down to neurasthenia'.

This brief outline is based upon a review of some of the more bread-and-butter writings of the period. Articles and letters from the *British Medical Journal* (BMJ) and *Journal of Mental Science* (JMS), some recently unearthed case books from the Lady Chichester Hospital for Early Nervous Diseases, at Hove, and the specific comments of leading lights such as Sir James Crichton-Browne (1840–1938), the 'Doyen' of British Psychiatry at the time. It is an attempt to reconsider what

formal alternatives there were, in terms of psychotherapy, to the psychoanalytic school. There is good evidence that the strong neurological basis for British psychiatry persisted, as reflected in the dominant topics of the JMS, taking on board aspects of continental theories, but more particularly the French than the Freudian or German schools. Furthermore, although expressed in language that seems down to earth or non-technical, it did represent a thoughtful, clinical and skilled approach to treatment. Psychological treatment was perhaps best defined by Emanuel Miller (1930) in his volume on *Modern Psychotherapy*, who reckoned it to be 'any form of healing which has as its object treatment by mental influence'. Thus, Miller could include analytic methods as well as hypnosis, hypnoanalysis, suggestion, auto-suggestion, and re-education. In a leader on 'Practical Psychology' (February 11, 1933, p.237), the BMJ suggested it was difficult to find one work on psychology 'that the hard-working professional man or woman can understand, or that does not require a preliminary education in the peculiar technology of the philosophical school that has created it'. Recommending a recent publication from the National Council for Mental Hygiene, as representing 'sound ideas in straightforward and intelligible language', a particular note was made as to the value of 'training in constructive thought, reading of books, the making of clothes, the cooking of food' and, of course 'keeping up the life-giving flow of interchange with our fellows'. Such a multiplicity of theories was reflected also in the book *Psychotherapy and Private Practice* published by the American therapist D.A. Thom, the review of whose work evoked the following comment. 'We must not suppose that our patients' conflicts are always deeply buried. There is a danger of dragging our line along the bottom while the fish are swimming near the surface' (Hamblin Smith, 1934).

The British Critics

It may be postulated that the British resistance to psycho-analysis was in itself a form of denial, and indicative of the perverse state of British psychiatry. However, one could suggest that the overtly critical opponents of Freudian doctrine – famously Charles Mercier, Clifford Allbutt, J. Shaw Bolton, Sir Robert Armstrong-Jones, and Sir James Crichton-Browne, – understood the structure of their resistance. They wished to terminate the nonsense that they deemed to be 'relevant to life in an Austrian or German frontier town but not relevant to ordinary English life'. Such at least is the way in which Sir Robert Armstrong-Jones put it at the Medico-Psychological Association (MPA) in 1920 (Armstrong-Jones, 1921). Perhaps the most virulent attack on psycho-analysis and its works was that by Joseph Shaw Bolton, Professor of Mental Diseases at Leeds University (the first psychiatric chair in Britain), in his exposé-cum-caricature. 'The Myth of the Unconscious Mind' (Bolton, 1926). Mocking Freud's aspirations ('Freud was conceived during a great European war . . . can it be merely coincidence that his greatest triumphs occurred at the period of the recent European war and the Treaty of Versailles') as well as his method, which he saw as the weaving of 'random association, truth and inference into a concrete whole', Shaw Bolton suggested that in this 'pseudo-psychology' if 'the positive turns up wrongly, it is only because in this instance it really represents the negative'. He also gave 'a glimpse into the unhealthy meanderings of the "unconscious mind" of Freud,'

by reconsidering one of the dream interpretations, which he regarded as similar to the 'descriptions from my mental patients'. Not content with deriding Freud as an unscientific charlatan, he even hinted at money-grabbing quackery by pointing out that 'interpreters of dreams have probably never failed to find clients, and have certainly never omitted to please them'.

To Armstrong-Jones and Crichton-Browne, psycho-analysis was likewise unscientific, pornographic and sought to reawaken the awful monsters of degenerate neurosis and constitutional incompetence that orthodox practice strove to bind over and divert. Crucially, it was useless in the asylum which remained the corner stone, for better or worse (cf Crammer, 1994), of the career structure of British alienists. For example, amidst a long-running series of letters in the *BMJ*, on the topic of research in mental disease, an asylum medical officer, Dr Atkin, wrote of the muddle surrounding the shibboleths of the 'new psychology'. He continued:

Some physicians derive a peculiar sense of satisfaction in being able to say that the suicidal tendency of a melancholic is due to sadism directed against a loved object that has been introjected within the ego of a person who suffers from libido-fixation at the oral and anal narcissistic stage, but one would like to see the practical utility of this discovery when one proceeds to treat a melancholic in the ward of a mental hospital. (Atkin, 1932)

Unforgivably psycho-analysis demanded a language and a time-course incompatible with public medicine or the public purse. Not least, the establishment of the Maudsley Hospital and its precursor, the Pathological Laboratory of the London County Asylums at Claybury, under Frederick Mott, with their somaticist commitment and the later development under Aubrey Lewis of a scientific social psychiatry, proved a formidable counterweight to the continental sirens. As Lewis himself wrote, 'the claims of psycho-analysis to explain all human behaviour diverted attention from the social causes and effects of mental abnormality' (Shepherd, 1980).

To take an obvious, public, and colourful example of opposition, it is useful and important to consider the later 'Thoughts' of Crichton-Browne. He must be seen as representing the tradition of neurological, phrenological, British eugenicist psychiatry that still believed in a moral management and mental hygiene (Neve & Turner, 1995). Alongside attacks on hypnotism as a treatment (he saw it, as Charcot did, as in itself a disease) and seeing such procedures as manipulating patients and their illnesses, he rejected what he called 'Freudism', regarding it as another deviant therapy. A notorious *Lancet* article (Crichton-Browne, 1920) fully acknowledged the relationship between insanity and infantile experience, (not surprisingly, since he himself had written spiritedly, in his first published paper, about the 'psychical diseases' of childhood back in 1860), but depicted the 'anti-repression method' as philosophically incoherent and naturally cruel. Incoherent because far from being 'repressed', the material was all too present in the memory of the suffering patient. The cruelty came by digging into this wound, under the illusion that something called the unconscious was being newly exposed for beneficial purposes. In his view this practice, instead of turning the patient's attention to diverting activities ('much sound psychotherapy lurks behind the sweat of the brow') contradicted all accepted principles of

moral management by 'disconnecting the disturbed mind from the physical environment where relief might truly be found'. As he pointed out, 'rubbing a raw surface has not hitherto been found conducive to healing'. By contrast, the healing distractions of field work, poultry keeping, and of course basket weaving were (in his late Victorian perspective) truly therapeutic occupations.

It is important to stress that while James Crichton-Browne did find the sexual nature of the purported, Freudian, internal world offensive, in no sense could he be said to be rejecting a psychological approach. He simply wished to keep the psychological connected to the external and physical, rather than returning the damaged psyche to an underworld that was the invention of a false science. There were, in his mind, and reflecting his lifelong engagement with research into the mysteries of brain function, alternative nervous pathways that could be and should be developed. Anxieties could not be 'enucleated like an encysted tumour'. The only way to dispose of them was to think of something else (a kind of neuro-cognitive restructuring), or to circle round them at an ever-increasing distance in thought until they were lost sight of altogether, or to 'blunt the sensitivity of the cerebral centres by sedatives and narcotics'. While he agreed that medical men must 'occasionally elicit unsavoury truths', he nevertheless insisted that they 'need not go boring in search of veins of pruriency'. He despised the 'mind undermining' that 'ferrets out verminous reminiscences'. Considering his Scottish origins it is striking that he could also write that 'Freud resembled Socrates as much as a toadstool does a British Oak'. Some of this criticism, it must be admitted, might reflect a potent anti-Germanic (and possibly anti-semitic) trend in British psychiatry at the time. Given the increasing numbers of German psychiatrists emigrating to England in the 1930s, an historical understanding of this process would require a more complex and detailed review of the individual responses and relationships in question (see Peters, this volume).

Neurological Psychotherapies?

Part of this rejection, though, was firmly based on theories of reflex cerebral activity and associated mental development, such as Crichton-Browne had researched energetically in his earlier asylum days. This circuitry was deemed essential to the neurotic mental symptoms with which patients presented. Brains could literally be modified by the appropriate medical reactions whether by appropriate feeding, skilful psychological massaging or simply, but professionally, saying the right things. Thus, at the 1920 annual meeting of the MPA a speaker insisted that 'ideas of decency, bestiality and so on were not built on instinct but on the supragranular layers of the cortex'. Another version of this concept suggested 'all re-education is based upon the existence and utilisation of alternative paths (in the brain) along which the patients may learn to send impulses' (Monrad-Krohn, 1921). He concluded that the 'functional disturbances are in all probability dependent on transitory, high level lesions of organic nature', and the formal treatment method of 'Suggestion' was thus a form of neural re-education. In fact, a range of variably sophisticated and formal psychotherapy methods was established in British private practice, with the additional use of nursing homes, hydros, and the physician's personality. As William Brown (the Wilde Reader

in Mental Philosophy at Oxford) put it, 'mental analysis is not enough, since the patient requires help in a re-synthesis of his attitude towards life' (Brown, 1939). Even the long sea voyage, as exemplified in the 1942 classic film *Now Voyager* (in which psychiatrist Claude Rains 'cures' dowdy spinster Bette Davis) was considered a formal, socio-physiological therapeutic measure, despite often being mocked as a means of getting rid of an over-demanding patient.

Maurice Craig, a lecturer in psychological medicine at Guys Hospital, in his textbook (Craig, 1912) outlined 5 methods of psychological treatment, using a mere 3 pages in a chapter on treatment of 45 pages. These were: (1) therapeutic conversation, (2) psycho-analysis, (3) occupation, (4) suggestion (including hypnosis), and (5) re-education. In other words, Freud's approach was one among many, and not especially prominent, at least in the pre-war period. The relatively pro-analytic writer, and Harley Street psychiatrist, Paul Bousfield, similarly laid out a range of techniques of treatment in his populist book on *Functional Nervous Diseases* (Bousfield, 1926). His 'Resumé' included 'Direct and Indirect Suggestion' (the latter involving several interesting ploys of planted information), 'Mental Re-education', which included 'General Re-education', 'Concentration of Memory' and 'Remedial Exercises', and finally Psycho-Analysis, 'frequently a very painful and tedious operation' (p.73). It is clear, therefore, that the accepted task of the psychological healer was to help lay down new pathways of thought and feeling, in the reflex circulation of the brain, thus restoring the malfunctioning parts of the higher association areas. This conception was very much in the British tradition of Laycock and Hughlings Jackson, Ferrier, and Gowers. Some critics of Freud even took the view that his early experience as a neurologist had been exploited as a scientific facade for the unreliable work on dreams, free association and the universalities of the ego, id, and superego.

Such criticism also extended into a rather bluff, very British, conviction that simple facts and simple language, rather than complex, speculative, neologisms, were a necessity in the realities of the clinical situation. Thus, a 1932 review in the BMJ, of Mr R.A. Howden's *The Mind in Conflict* (with an introduction by William Brown), felt that 'unfortunately it discloses a tendency to clothe theoretical assumptions with the semblance of concrete reality', and that this led to the 'risk of misleading an uninstructed public by giving to airy nothings a local habitation and a name' (p202). The average British GP seems to have been particularly impervious to psycho-analytic ideas, as was acknowledged by the regular contributions to both the *Lancet* and BMJ that attempted to urge on the 'new psychology'. In a typical post-graduate lecture at Charing Cross Hospital Medical School, the hospital's senior physician, David Forsyth declared that 'medical psychology had been revolutionised' in the last 25 years, but accepted that 'Freud's discoveries have been looked at even more askance by the medical profession than by the laity' (Forsyth, 1932). Lack of psychology in the medical curriculum, an organic bias, and the need for the doctor 'not to seek to exercise any authority, moral or otherwise' were the reasons given for this sceptical medical position. But given that this was also 'the exact contrary to the usual professional relationship' (as Forsyth acknowledged), it was hardly surprising. Ever since the Reverend Francis Willis had (as the myth went) 'fixed' with his eye the manic George III, British physicians had been rigorously trained to tell their patients exactly what to do. As Armstrong-Jones put it 'introducing

the Greek gods and heroes into their patients' families' (e.g. Electra, Narcissus, Oedipus) would have generated 'uneasiness, and even fear' amongst medical men (Armstrong-Jones, 1934).

A further source of concern was the continuing schismatic tendency of the psycho-analytic movement, even its supporters acknowledging the problems thereby created. Thus, Dr E. Armstrong Bennet, the Jungian analyst, who lectured on the treatment of the psychoneuroses, admitted in the subsequent discussion that 'the Freudian system was at present undergoing considerable changes. There was no unity of approach and therefore the whole subject was rather confusing' (Bennet, 1931). More colourfully, the aforementioned Assistant Medical Officer from Park Prewett Mental Hospital, Dr Atkins, complained of the 'great trinity' (Freud, Jung, Adler); the 'fervent disciples of McDougall, Pastor, Pfister, Kempf, Stekel, Rank (trauma of birth!), Groddeck etc', the psychology 'based on the doctrine of dialectical materialism . . . becoming fashionable in the USSR', and Professor Jung convincing himself 'that his interpretation of a dream is nearer the truth than either Freud's or Adler's, and so on ad infinitum' (Atkins, 1932). From within the movement the leading Adlerian, F.G. Crookshank (1932), admitted there was 'a great deal of washy and spineless eclecticism that degenerates into clinical opportunism, if not humbug', while also putting forward a strongly psycho-physiological model whereby 'conscious or unconscious psychical states' were linked with 'cerebral and spinal connections'. Thus 'the migrainous man has astigmatism and practises coitus interruptus;' 'the dyspareunic woman has a misplaced uterus and a husband whom she hates;' and 'the aerophagic doctor bolts his meals, is in debt, and has a flabby abdomen'. Such 'so-called "functional" cases are the despair of the thoughtful practitioner', but the 'joy of the charlatan, and are often enough "cured" by New Thought, Christian Science, osteopathy and the like'. This odd confection in fact bordered onto more respectable approaches, as outlined by Langdon Brown with his notion of the 'organic unconscious'. The 1932 BMJ leader 'Psychoneuroses and the Endocrines' (Vol i, pp.245-6) summarised a lecture of his, agreeing that 'the unconscious mind must be explored physiologically' but regretting that 'anaesthetic hallucinations of homosexual assaults' could neither be surgically removed nor 'dissolved' by psychotherapy.

Given this physicalist leaning, it is not surprising that in the typical advertisements for private nursing homes, for those with nervous illnesses, it is clear that a practical, semi-medical, activity-orientated, psychotherapy was dominant. The advertisement for Camberwell House (telegram 'psycholia'), advised of hard and grass tennis courts, putting greens, bowls, croquet, and squash racquets. There was also occupational therapy, callisthenics and dancing classes, x-ray and actino-therapy, as well as prolonged immersion baths, operating theatres, and a fully equipped pathological laboratory. In Hereford a mansion called Holme Lacy (JMS, 83, p.viii) offered hydrotherapy (including continuous colonic irrigation, the needle spray, and the Plombières Douche), heliotherapy, etc., (including ultra-violet and infra-red light, and lamp baths) and 'congenial occupations and crafts for cases considered by the medical staff suitable for this form of treatment' (JMS, 1937, p.vii). Being so many feet above sea level also seems to have had its cachet, deriving perhaps from more traditional ideas as to fresh air and recovery away from the crowded urban zones, while

amusements, walks, the wireless, and dances were included in the programme. Holme Lacy had apparently been 'converted' into 'a hospital for the active treatment of ladies suffering from all forms of nervous and mental breakdown', so was relatively modern in its inspiration. Nevertheless, amongst these routine advertisements there is never a whiff of psycho-analytic jargon. This may well be related to the 'deplorable' misconception 'that the investigation of the neuroses means the discussion of sexual topics with young girls; and psychotherapy, the recommendation of fornication' (Crookshank, 1932).

Managing the Nervous

Trying to establish exactly what was done under the rubric of psychotherapy, whether in the consulting room or at the nursing home, leads to considerable variations in both language and practice. A nice outline, 'Principles of psychotherapy as applied to general practice', can be found in the BMJ of 1934. The author, C. Stanford-Read, was lecturer in Psychological Medicine at the Bethlem Royal, as well as being Clinical Psychologist at the West End Hospital for Nervous Diseases. He outlined the ideal psychotherapist, first steps in psychotherapy, the use of suggestion, treatment by hypnosis, some points in suggestive therapy, auto-suggestion, the value of persuasion and re-education, and at the end, the analytic methods. He even advised the GP simply to listen, because 'when a secret fear is shared, with another this feeling of social ostracism is removed and biological security and happiness tend to be re-established'. His approach was based upon the sense that neurosis was 'the result of a defective adaptation to life stresses', and so 'all potent suggestive influences' can work for good or ill. Such suggestion also required anything that might lessen controlling cerebral forces, and he even declared that suggestions could modify 'salivary or mammary secretions, the peristalsis of the bowel, vasomotor processes and the functions of menstruation'. Under the notion of Persuasion, he included 'the development and encouragement of useful and personal interests, which will tend to drain off energy from pathological channels into healthy ones'. This was deemed more scientific than merely attempting to divert the patient via 'a change of scene' (i.e. the long sea voyage) whereby constant distraction allowed symptoms to wither away 'from inattention'. However, although he concluded that 'instilling cheerfulness, hope and courage' were basic ingredients, nevertheless 'the less we use the word cure in psychotherapeutic practice the better'. Using the analogy of 'poorly developed chests' breaking down under 'respiratory strain', he stressed that 'constitutionally poor mental soil' will mean that 'we cannot make some individuals normal but perhaps can alleviate to some extent and render life more bearable'.

This somewhat pessimistic view of therapeutic benefit was echoed in a paper on 'Practical Considerations' by a Dr James Flind (Flind, 1939). He reckoned anyway that only 4 out of 100 patients were suitable for 'prolonged analytic psychotherapy', while stressing the importance of the practical organisation of the hospital in terms of physical care, social work, and help with 'everyday activities'. He noted in exasperation several patients who had 'undergone prolonged analytical treatment without benefit', yet who were 'exceedingly difficult to persuade that there is anything more in life than a continuation of

the analysis'. In the subsequent discussion, the contrasting benefits of briefer approaches were highlighted. Thus, Dr Doris Odium (JMS, 85, p.895) outlined a 'creed' in relation to psychotherapy, based on a belief in the psychoneuroses as illnesses, a belief in early and preventive treatment, a belief in child guidance, ('real psychotherapeutic bread', but 'not of the long or deep kind'), a belief in the need for inpatient facilities (one of the most valuable factors in treatment being, apparently, visits to Woolworth's), and a belief in the psychosomatic approach. Dr William Brown (BMJ, i, 1932, page 567) declared that 'the appropriate suggestion could strengthen the willpower, enabling the mind to contemplate success with sufficient conviction'. Furthermore, he felt that hypnotism, in particular, 'could produce a reorientation of subconscious psychical force, and an enhancement of willpower and transformation of character'.

This conviction of the accessible connection between psyche and soma pervades other references. At a conference on mental health, organised by the National Council for Mental Hygiene, in January 1936, Dr Hugh Crichton-Miller (of the Tavistock Clinic) reckoned that a cure was effected by 'a doctor's words and manner rather than by his pills and potions' (p.226). Thus, if a patient 'accepted the proffered reassurance and achieved equanimity in place of apprehension, a relative improvement in physiological functioning was bound to follow'. Other speakers talked on 'Problems of Domestic Relations' and 'The Priest and the Doctor in Nerve Cases'. A letter from a Glasgow physician, a Dr Shearer outlined a remarkably successful dispensary practice, where a 'simple rational psychotherapy' sufficed to clear up the symptoms, after 4 or 5 attendances (BMJ, i, p.697). Apparently, this was because he saw patients who had 'had no time to elaborate their symptoms'. In terms of deciding the method of approach, Dr Lindsay Neustatter (1936) concluded that he would employ analysis if the patient had time, was intelligent and had insight, would use suggestion, hypnosis or persuasion if the patient was suggestible and had little time, but for a residue of patients he would use simple reassurance with medicine and 'spend little time at it'. He acknowledged openly that 'we should not be too proud to admit that there are a large number of cases who are unresponsive to treatment'. In particular, he grumbled at the now fashionable nature of psychoanalytic practice, which allowed patients to 'ramble aimlessly on with a sort of ill defined and pious hope that just talking is going to make them well'.

Given this sceptical atmosphere, there even developed an argument as to whether psychotherapy was within the range of medical services that could be given under insurance through the Medical Benefit Consolidated regulations. Legal referees of a particular case agreed that psychotherapeutic treatment did involve a special skill and experience, and that the practitioner had carried out special academic or post-graduate study. It seems that they felt psychotherapy 'required the adaptation of the mind of the student to conceptions more intangible than those of general medical science' (BMJ, 1933, p. 107 supplement). In general, financial considerations are hard to clarify from these sources, but concern as to lay therapists competing with medical men and lowering the status of the art (BMJ, 1939 ii, p.139) or the question of the recognition of invalidity awards for psychoneuroses in the tropics (BMJ, 1934, i, pp.726-7) do occasionally surface.

Of course, alongside these versions of practice, considerable direct criticism of psychoanalysis continued to arise. Professor William McDougall, in his book

Psychoanalysis and Social Psychology, (1936), insisted that there was evidence that 'what the Freudian analyst extracts from their patients they first implant in them'. Dr Edward Mapother (at a 1936 conference on Functional Nervous Diseases in the Fighting Services) felt there was little real need even to discuss psychoanalysis, suggesting that its efficacy was exaggerated and that memories were 'not in any real sense buried'; the results he had seen were 'far from uniform and much less dramatic' than those he had read about. It reminded him of the fashion to open up all sorts of foci of surgical TB, scraping them with a sharp spoon, 'like a dog after a rabbit'. It was time, therefore, actively to reconsider this process of 'psychological rabbiting' (*Proceedings of the Royal Society of Medicine*, 29, pp. 864-5). Given some of the complex language used by the proponents of psychoanalysis, it is not surprising that it generated criticism. For example Edward Glover, in *The Principles of Psychiatric Classification*, (1932) wrote as follows; 'the arrangement is made in accordance with the amount of introjection, and endo-psychic resolution of conflict on the one hand, and on the other with the amount of projection and exploitation of reality relations in the interests of resolution of conflict'. Yet even amidst this Freud-speak, there is a hint of neurological ancestry in his description of schizophrenia representing a 'multiplicity of primitive fixations to early ego-nuclei'. This resort to an 'obscure terminology, which moreover varied from one exponent to another' also gave openings to those committed to a physical explanation for the psychoneuroses. At the 1930 Irish meeting (Bennet, 1931) already mentioned (BMJ, 1931, i, p.17), the roles of hypotension, microbic infection ('thus immunisation by a suitable antigen was often followed by recovery'), and conditioned reflexes were championed. Thus, a Professor Harold Pringle thought that since 'wrong reflex channels had been established', the aim of treatment was to 'reopen the normal channels'. This was the Crichton-Browne school of psychophysiology in full cry.

Medical records of the Lady Chichester Hospital, Hove

If we wish, however, to look at the practical conduct of psychotherapy in Britain in the 1930s, what sources are available? It was routine for private institutions (such as that in which T.S. Eliot placed his wife) to destroy the records soon after the patient left or died. There are anecdotal case-reports, by various practitioners, but these are designedly selective. However, recently, an archive has come to light of the notes of the Lady Chichester Hospital, Hove. This was founded in 1905 by the pioneering Dr Helen Boyle, one of the first women to work as a psychiatrist in Britain. Designed as a treatment centre for 'early nervous and mental diseases' (Boyle, 1914), it ran successfully for many years, expanding into outpatient clinics, larger premises, and one of the earliest children's inpatient units (see Hingston, 1955).

Although the archive is yet to be sorted and classified, it has been possible to review a selection of standard inpatient notes from the 1930s. A random sample from the years 1930, 1934, and 1939 gave useful insights into the standard 'psychotherapeutic' treatment. The great majority of patients were women (it had initially been only for women and children), 70% in their 20s and 30s. There is some class selection, in that payment was required, but often individuals were subsidised by charitable bodies. The most striking aspect of the notes is

their format. The first two pages include subheadings for a range of physical conditions, including the cardiac, endocrine, and nervous system, and a 'special report'. There is then a page for family history and personal history and the history of the present illness, and then the daily notes. Weight charts, medicines given, (e.g. 'mist pot cit') and various temperature and blood pressure charts are carefully filled in. The range of treatments commonly extended to forms of massage and exercise, bed rest, iron or vitamin injections, the steam bath, a drill class, and dietary additions such as extra milk or malt and cod liver oil.

When, however, we come to the language used to diagnose these conditions, it is clear that the impact of Freudian, Jungian, or even Adlerian terms is markedly lacking. Although sexual problems and masturbation are sometimes included, the only terms I came across that were related to psychoanalytic concepts were the 'subconscious mechanism', theorised as causing the speech problems in a 12 year-old boy, and an 'inferiority complex' in an easily fatiguable 28 year-old woman. More often terms such as 'depressed' or 'neurasthenic' are used. The language is intrinsically ordinary, typical of the 'common sense' British. People were advised to 'stop looking back and to try to help others'. Phrases such as 'her mind is in a muddle', and 'she is worrying a lot' are typical. There are some concerns about the home background and upbringing (e.g. 'mother not in a fit state due to alcohol'; 'a grievance against father'), but these are brief. One individual is advised that 'people ill with their nerves do behave irrationally at times'; another is deemed 'upset and hysterical', and 'unequal to tackling home life for the present'. There is little systematic diagnosis amidst the anxiety neuroses, nervous breakdowns, character defects, lassitude, and morbid fears. Physical symptoms such as tremors, shaking, headache, and sleeplessness abound.

There are also often critical comments made about the patients, of whom about 20% left precipitately. One is described as a 'chronic grumbler', another is 'sulky', another is, exasperatingly, 'worried over trifles'. It is not uncommon for individuals to be asked to leave because they are causing a nuisance. An hysterical, bad-tempered 18 year-old is caught stealing and fabricating things, so gets sent off to the Maudsley Hospital. These may be 'early nervous' cases, but they are upsetting people on the wards, are of a 'difficult temper', are unsafe to keep, or are too talkative. It is also quite clear that a number of patients suffer from quite serious psychotic illnesses, and have to be sent to the asylum under certification. In other words, it seems likely that the Lady Chichester Hospital was sometimes used as a last resort by families trying to avoid certification, and then the language of 'melancholia', and 'imagining things' and 'hearing voices' emerges. One person is even described as 'very schizophrenic', another as anergic, and several as having definite 'delusions'.

In summary, it is very difficult from this kind of front-line evidence to see anything other than a suggestive, re-educative, and very down-to-earth physical approach to the notion of psychotherapy. It is clearly a hospital environment, and doctors and nurses are regularly carrying out assessments and investigations. It cannot, of course, be claimed that this hospital was representative of all forms of psychotherapy, but it fits in with something deemed to have a neurophysiological basis, and deemed to be culturally attuned to the kind of clientele it was serving. The proprietor, Dr Helen Boyle, was actually appointed the first woman president of the RMPA in 1938, so it is clear that she represented a mainstream, of

some sort, in British psychological medicine. In fact, in her presidential address to the College entitled (curiously) 'Watchman, what of the night?' (Boyle, 1939), she stated clearly that she made 'no attempts to deal with theories, which would be beyond me'. She did, though, suggest that it was possible to 'distinguish the gradual emergence of a type of psychotherapy which being a compromise as is dear to British hearts may ultimately be designated as the British school, and be in fact a sound and sensible practice, avoiding extremes and yet incorporating established truths with valuable British contributions'.

Conclusion

In summary, it would seem that there was a consciously structured form of psychotherapy, the threads of which can be traced from the practices of Victorian moral treatment, running through the brain studies of Crichton-Browne at Wakefield and the management of shell shock in the First World War, and flowering in the outpatient departments of the 1930s. Less strikingly articulated than the analytic school, it tried to embrace both specialists and GPs and to reinforce the often chronic task of dealing with neurotic patients. It had to be simple in its language and was deeply suspicious of suspect, degenerate, continental techniques that contradicted the accepted principles of the nervous reflex. In his 1939 Maudsley lecture, entitled 'A Revaluation of Psychiatry', D.K. Henderson suggested that 'while it may not be possible to transform or change what is known as the individual substance or character . . . it may be capable of considerable modification'. This notion of compromise and of 'psychobiology' (a Meyerian term) was very much the heart of the matter. After all, a typical psychiatric outpatient was 'not of the deeply thoughtful class, and the psychotherapy must be of the common-sense order' (Skottowe, 1931). This brief sketch may reflect that comment and has of necessity been selective, but further research into what doctors actually said to their patients, and what the patients thought about this 'therapy' remains an intriguing task.

Acknowledgements

The invaluable help of Dr. Michael Neve, for his historical scholarship, and of Ms Christine Warner, for her preparation of the manuscript, is gratefully appreciated.

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9 Twentieth century British clinical psychology and psychiatry: their historical relationship

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Psychological ideas, in the sense of concepts that would be regarded as primarily lying within the province of the discipline of psychology, have influenced psychiatry ever since the latter's inception. There is thus a clear and unavoidable link between the two. Psychology is indeed one of the disciplines that must be regarded as providing a fundamental basis for work in psychiatry.

This chapter is mainly concerned with a much narrower issue than the overall relationship between psychiatry and the discipline of psychology. The principal concern is that between clinical psychology as a specialist area of applied psychology or psychological practice, on the one hand, and psychiatry (mainly general adult psychiatry) on the other. The focus is on the historical development of the link between these two professions in the British context, in so far as it has led to an identifiable profession of clinical psychology as practised by psychologists. The wider interaction between psychology and psychiatry remains to be explored elsewhere.

The term 'clinical psychology' appears to have been coined by Lightner Witmer around the time that he established a psychological clinic at the University of Pennsylvania in 1896. Penniman (1931) cites an official document of the university which describes the clinic as being for 'the study and remedial treatment of mentally or morally retarded children, and of children suffering from physical defects which result in slow development or prevent normal progress'. This, taken with other accounts of the founding and early role of the clinic provided by Witmer himself as well as others (e.g. Fernberger, 1931; Witmer, 1907), suggests that Witmer's concept of 'clinical psychology' was not that of the present day. The work of this clinic, which had a predominantly educational emphasis, would now be regarded as being more within the realm of educational psychology. Nevertheless, Witmer went beyond merely introducing the term 'clinical psychology' in that his clinic was important in developing an applied emphasis in psychology based on the problems of individuals. In this sense Witmer employed what could be described as a clinical approach even though the context was much more related to education than to health.

Herein also lies a major historical difference between psychiatry and clinical psychology. Psychiatry has its roots in European medicine, with European ideas often heavily influencing the New World, at least until relatively recently. The reverse is true of clinical psychology which was first established in North America;

its development in Britain and other European countries followed more recently. This is illustrated by the fact that many of the earliest and most influential journals concerned with clinical psychology are American. Examples are the *Journal of Abnormal Psychology* founded in 1905 and the *Journal of Consulting Psychology* (now the *Journal of Consulting and Clinical Psychology*) founded in 1937. A British journal specifically concerned with clinical psychology did not appear until the early 1960s so that it is difficult to deal with the subject matter of this chapter fully without at least some acknowledgement of transatlantic influences. Although clinical psychology in Britain emerged later than in the USA, it has also had its own indigenous roots. The main emphasis in this chapter will be upon these indigenous influences and developments, but this is by no means to deny the very significant impact of what went on in North America. An account of the historical development of clinical psychology from a largely American perspective has been provided by Reisman (1991).

The Background

Clinical psychology, at least when considered as an area of professional practice for psychologists, only got under way to any significant extent in Britain during and immediately after the Second World War. It was to some degree at least a consequence of the use of applied psychology in military settings. Nevertheless, as will be described below, it was also dependent upon influences that extend far back beyond that period. A formally established base for clinical psychology, with an officially recognised career structure and salary scale, was then incorporated into the National Health Service, when that uniquely British institution was founded in 1948.

Wartime clinical psychology arose within a particular context. A number of overlapping or interrelated background factors or trends can be seen as making a particular contribution to its genesis and as creating that context.

The first factor lies within the medical profession itself. Psychologists would have found it extremely difficult, if not impossible, to get a foothold within hospitals and other health care settings without at least some support from the most powerful and influential of the professions involved in health care. Within the medical profession itself, the influence of psychiatrists would clearly have been the most critical. This is not to claim that all psychiatrists would have welcomed the introduction of the new and sometimes brash profession of clinical psychology. Despite this, many significant psychiatrists certainly contributed to creating the climate in which it could take root.

For a considerable time, extending back into the nineteenth century, some psychiatrists appear to have had an appreciable interest in the newly developing discipline of psychology. This can be illustrated by looking through the volumes of the *Journal of Mental Science* for the first half of the twentieth century. This journal often carried quite substantial reviews of contemporary books of a psychological nature. One noteworthy example of this is Mapother's (1928) lengthy and adulatory review of Spearman's (1927) classic work, *The Abilities of Man*.

That work on mental measurement in the tradition of Spearman impressed at least some psychiatrists quite strongly is shown by Mapother's (1928) comment

that, 'It seems quite likely that this book might have on both normal and morbid psychology the sort of influence that *The Origin of Species* had in biology'. It is noteworthy that Mapother also added that, 'It is especially desirable that workers trained in the analysis of mental functions upon the lines indicated by Prof. Spearman, should cooperate with clinicians in defining the problems of both normal psychology and psychiatry and attempts at their solution'. Here, he is clearly indicating that people who could only be regarded as psychologists, i.e. those trained in the area of mental measurement, should work alongside clinicians (psychiatrists, in this context), rather than that psychiatry should just adopt methods and findings developed within psychology.

Many other significant books by psychologists were reviewed in the *Journal of Mental Science*, again often with approval. From around 1930 onwards, this same journal also started to carry a regular flow of papers dealing with different aspects of mental testing as applied in a clinical context. Many of these papers were by medical practitioners working in the field of mental health but with the passage of time, an increasing number appeared under the names of psychologists. These were predominantly academic psychologists who had strayed into the field of mental abnormality, rather than psychologists mainly working in clinical settings of which there were then very few.

Although by far the most common form of psychological paper published in this way was based on mental testing, contributions began to appear on such things as conditioned reflexes, memory, gestalt psychology and the relationship between language and conceptual thought (e.g. Blackburn, 1940; Burrige, 1930; Hutton, 1943; Wohlgemuth, 1930).

In addition to this general interest of many psychiatrists in certain developments within psychology, there was a prominent group of investigators who originally qualified in medicine but whose major scientific contribution can be regarded as falling substantially within the field of psychology and related areas. These include such figures as W.McDougall, C.S.Myers, and W.H.R.Rivers. Together with others holding similar interests, these three were all involved in the treatment of shellshock in the First World War. They were also advocates of interventions for this problem that were more specifically psychological than those which often found favour in military hospitals, especially as practised by neurologists (Stone, 1985).

One of this group, McDougall, then went on to hold a number of senior academic posts in psychology at Oxford, Harvard and Duke Universities, as well as becoming the author of a number of influential psychological texts. He is rightly regarded as a much more important figure in the history of psychology than in medicine or psychiatry. Whilst still a temporary military medical officer, he was possibly the first to advocate the need for a 'clinical psychology' in the British context. In that paper (McDougall, 1919), he was clear that the clinical psychology being advocated was separate from psychiatry and that it involved the application of specifically psychological findings and theories in a clinical context. However, the issue as to who should practise clinical psychology was not considered. Had the question been put, it is possible that McDougall would have seen this as a role for medically qualified people like himself who had then chosen to enter psychology, but this is certainly not explicitly stated.

An important development linked with this group was the formation of the Medical Section of the British Psychological Society in 1919 (see: Rivers, 1920).

The first chairman of this section was W.H.R. Rivers himself and the initial list of members contains a number of those who, like Rivers and Myers, had both been involved in the treatment of shellshock and had developed strong psychological interests leading to them already being prominent members of the Society. This Section, which continued to have a strong medical representation amongst its membership, cannot have done other than to contribute to linking psychologists and psychiatrists, or at least those amongst the latter of a more psychodynamic persuasion, who appear to have been particularly attracted to the Society and its Medical Section. The Section soon spawned a journal, the *British Journal of Medical Psychology*, which first appeared in 1921 and has often had a psychiatrist as its editor, despite being published by an organisation whose overall membership overwhelmingly consists of people without medical qualifications.

Other developments associated with the group of medically qualified psychologists, and especially Myers and Rivers, were in industrial (now more commonly known as occupational) psychology. The First World War had created an understandable concern with the productivity of workers in essential industries, and especially those working in munitions factories. This government interest in productivity extended into the post-war years and a number of medically qualified psychologists, along with many other psychologists who lacked a medical background, worked on projects concerned with problems such as fatigue in industrial workers (Stone, 1985). In fact, C.S. Myers was the first Director of the National Institute of Industrial Psychology (NIIP), when that organisation came into being in 1921.

Stone (1985) offers a much more detailed account of these developments. A key factor that carried over into the later development of clinical psychology in Britain is that those working on industrial problems adopted a much less mechanistic approach than their contemporaries in the USA. Rather than seeing the worker as a passive responder to external environmental circumstances, they adopted what Stone has described as a much more 'clinical' approach, based to some extent on the experiences of the medically qualified psychologists who had dealt with shellshock. For example, rather than viewing fatigue in purely mechanistic or physiological terms as merely the consequence of continuous and prolonged physical exertion, the British scientists viewed it as having important psychological components. As Myers (1919) put it:

The physiological factor of muscular fatigue was now fast becoming generally negligible in industry, compared with the effects of 'mental' and 'nervous' fatigue and of weariness, want of interest, suspicion, hostility, etc.

This echoes shellshock, which was seen through the eyes of Myers and others as predominantly occurring in badly functioning military units with poor morale.

The stress on the psychological characteristics relating to fatigue led in turn to a concern with tests which might assess the level of such characteristics as well as abilities in industrial workers. The NIIP in fact put a large part of its research effort into developing tests for determining such things as aptitudes which were considered crucial for satisfactory work performance. The work in industrial psychology undertaken at this time had a significant influence on the

activities of psychologists, including those in military hospitals, during the Second World War.

It is also clear that some psychologists, in addition to those with medical backgrounds, saw applications in the field of mental health as a legitimate development of their work. Indeed, this would also have been an essential precursor for the development of clinical psychology. Whilst some psychiatrists, like Mapother and Aubrey Lewis, may have been influential in helping to welcome psychology into the field of mental health care, there also had to be psychologists who were both prepared and willing to accept the invitation. Here, the American example was certainly also a strong influence and is clearly mentioned in one of the first British attempts to discuss the role of psychologists in health care (Eysenck, 1950).

The oldest psychological journal in Britain is the *British Journal of Psychology*, which was founded in 1905 and in its very first volume carried a report of mental and physical tests applied to epileptic patients at the Claybury Asylum (Smith, 1905). Only a few papers that could be described as 'clinical' were published prior to the founding of the NHS, but those that did appear show a range of perceived relevance of psychology to clinical settings. As might be expected, there were a number of psychometric studies (e.g. Abelson, 1911; Slater, 1945). However, a variety of non-psychometric investigations also emerged and included investigations of memory in 'mental defectives' (Fildes, 1923) and those with brain injury, particularly a paper on the rehabilitation of the brain injured (Zangwill, 1947). Not surprisingly, psychologists appear to have seen their discipline as having a much broader range of practical relevance to health care than did psychiatrists.

Before leaving the influences that led to the full development of British clinical psychology in the Second World War and after, it is appropriate to include a few further comments on American clinical psychology. As already indicated, this got under way long before its British counterpart. The most extensive account of early American developments is provided by Reisman (1991). British psychologists would have been familiar to some degree with developments in the USA since many of the most influential psychological journals have always been American, and it has been difficult throughout the twentieth century to make a serious contribution to psychology without being aware of the American literature.

Prior to the Second World War, American clinical practice was largely dominated by work in psychological assessment, but therapeutic activities had become increasingly established as part of the role of the psychologist as well as that of the psychiatrist. For example, Ives (1991) reports that in the Detroit hospital in which she worked as a psychologist in the mid-1930s, about a third of psychologists' time was spent in conducting psychotherapy. The rest of the time was spent in interviewing and in administering psychometric tests. The therapeutic approaches then used by American clinical psychologists had some roots in educational procedures, but the practice of dynamic psychotherapy was taking increasing hold (Reisman, 1991).

A major development in American clinical psychology began in 1931. It was at this time that the American Psychological Association first started to dip its toe in the water with regard to developing recognised training programmes in clinical psychology. A 'Committee on Standards of Training for Clinical Psychologists'

was established in that year (Reisman, 1991). There were at this time about 800 people working as clinical psychologists in the USA. Despite this number, the first formal accreditation of clinical psychologists did not start to develop on a State by State basis until the 1940s. In 1937, Woodworth was still bemoaning the fact that it was not possible for the public to identify who was a properly trained professional psychologist.

It is not part of the concerns of this chapter to pursue this brief outline of the development of American clinical psychology any further. The significant point as far as the British scene is concerned, is that there has always existed a powerful model on the other side of the Atlantic which could, and often did, offer a clear example for British clinical psychology to follow.

Clinical Psychology and the War Effort

The above discussion has indicated that by the late 1930s and the start of the Second World War, a number of indigenous developments, together with the example of clinical psychology in the USA, made the time ripe for the actual appointment of psychologists to work in mental health settings. Indeed, the first appointments of psychologists to the staff of a mental hospital antedated the Second World War since J.M.Blackburn and P.E.Vernon were employed in the Maudsley Hospital in the late 1930s.

The Second World War raised again the question of mental health in servicemen. Even prior to the start of hostilities, J.R.Rees, Medical Director of the Tavistock Clinic and Alec Rodger, a prominent industrial psychologist from the NIIP, submitted a memorandum to the army medical authorities on the use of methods developed in industrial psychology to prevent neurotic casualties. Although the notion was rejected at this stage, later pressures resulted in the extensive use of psychological tests, like those already developed by the NIIP. These were particularly used for the screening of servicemen and the selection of personnel for particular purposes, such as those suitable for training as officers. By 1941, a Directorate for the Selection of Personnel was established in which many NIIP psychologists were heavily involved (Stone, 1985).

In September 1940, the British government appointed an expert committee 'to investigate and appraise the work of psychologists and psychiatrists in the services'. However, the deliberations of this committee were not made available until its report was published after the war (Report of Expert Committee, 1947). Partly in consequence of this, it is not clear as to when the report was actually written. The applications it envisaged for psychology have a heavy flavour of industrial psychology, involving such things as personnel selection and training, but the issue of stress and 'shell-shock' is mentioned as a problem to which both psychologists and psychiatrists could make a contribution.

One particular problem that arose in the war surrounded the inadequacies of the then available personality tests for use in selection and screening. H.J.Eysenck, brought to the Mill Hill Emergency Hospital in 1942 through the influence of P.E.Vernon, took a leading role in tackling this problem, basing his work on studies of large samples of both neurotic casualties and normal servicemen. Amongst other things, this led to the development of special

questionnaires and much of this work was reported after the war in Eysenck's (1947) book *Dimensions of Personality*.

Eysenck was by no means the only psychologist appointed to work in military hospitals during the Second World War. Apart from a small group at Mill Hill, others like Patrick Slater were associated with the Sutton Emergency Hospital and O.L.Zangwill worked in the Edinburgh Brain Injury Unit, where he carried out some pioneering investigations. In addition, Crichton Royal Hospital in Dumfries appointed John Raven, well known as the developer of the Progressive Matrices test of intelligence, to its staff in 1944.

Clinical Psychology Established

As has been indicated above, the influences that led to the creation of a profession of clinical psychology in the UK certainly extend far back before the advent of the National Health Service and to well before the Second World War. However, determining exactly when practitioners identifiable as clinical psychologists in the present sense first appeared on the scene is difficult. That inevitably is going to depend on the specific criteria adopted for defining a 'clinical psychologist', but a good case can still be made for identifying the point at which clinical psychology became firmly established and formally acquired a separate professional recognition in the UK. This is coincident with the founding of the National Health Service in 1948. It was at this point that a definite career structure and set of salary scales for clinical psychologists appeared. With these went an implicit acceptance that psychologists were to become a routine part of the mental health services, although it was to be some time before the vast majority of such services could boast the presence of a psychologist. The few who entered employment in the NHS around this time would have had no special training in clinical psychology and came from a variety of backgrounds.

For some time, the numbers of psychologists working in the NHS were quite small. The Trethowan Report (Trethowan, 1977) records that in 1962, there were only 198 working in the NHS in England and Wales, but that this number had risen to 585 by 1973 (both figures being for full-time equivalents). Official government figures for 1993 put the total number at over 2500. There were, of course, others in Scotland and Northern Ireland with a marked trend for Scotland to have more clinical psychologists per head of population than England and Wales.

Developing an accepted and characteristic method of training is one mark of a profession's development. In 1957 formal recognition was given by the Whitley Council to three postgraduate courses in clinical psychology (at the Institute of Psychiatry in London, the Tavistock Clinic, and the Crichton Royal in Dumfries). Of these, only the course at the Institute of Psychiatry has survived and has undoubtedly had a very significant influence on the development of clinical psychology in the UK. Not only have many well known names in the profession been associated with the Institute, like Monte Shapiro, Jack Rachman, and Gwynne Jones, but a substantial proportion of those running other postgraduate courses are products of the Institute.

By 1967, a further five courses had been established at other centres (Hall, 1993) and there were over 20 by 1990. Ironically, two of the original three

courses, those at the Tavistock Clinic and the Crichton Royal, had long disappeared by that time. The requirement for a generic training covering all major areas of practice in clinical psychology made the Tavistock course impossible given that clinic's limited range of clientele. The length of formal postgraduate training has gradually extended from being originally one year, to two years in the 1960s, while the early 1990s have found all courses offering a three-year training.

A separate identity for clinical psychologists within the British Psychological Society emerged with the creation of a Division of Clinical Psychology in 1968, based on an original Division membership of 163. Although by no means all qualified clinical psychologists are Division members, the steady and so far unrelenting growth of clinical psychology has been reflected by the rise in Division members which stood at 2,680 in 1993.

This considerable expansion in numbers has been matched by similar expansions in the types of work undertaken and in the range of client groups being served. In the 1990s, it is quite common to have clinical psychologists working in a range of non-psychiatric settings. These may include neurology, pain clinics, physical rehabilitation units, and a range of other general hospital departments as well as primary care.

Space does not permit anything like a detailed account of the post-war development of the profession. In consequence, this section will conclude by examining some aspects of the development of clinical psychology which have particularly involved its relationship with psychiatry.

Being to a degree under psychiatry's wing and with early posts in the NHS being created very much with the support of psychiatrists, the early clinical psychologists worked mainly in psychiatrically related settings, whether related to adults or children or with the learning disabled. The work almost entirely involved psychological assessment using formal psychometric tests and even projective techniques. Even by the mid-1960s, psychological assessment dominated training and practice; textbooks of clinical psychology of that era reflect this. That edited by Savage (1966) is entirely dominated by the issue of assessment. By contrast, an American text from the same general era by Sundberg & Tyler (1962), which had some influence in Britain, is still mainly concerned with assessment, but does devote a substantial minority of its space to therapy.

From the earliest days, psychologists were looking to be involved in therapeutic activities as well, and an early case for this was put forward by Eysenck (1950). The transatlantic influence was relevant here, since American clinical psychologists were already well established as providing at least some therapeutic services (Ives, 1991).

There were some early British clinical psychologists who had a psychodynamic orientation, especially those based or trained at the Tavistock Clinic, and some of these were probably involved to a limited degree in dynamic psychotherapy. Nevertheless, it was the development of behaviour therapy during the late 1950s and early 1960s that offered the first major form of therapy to attract the involvement of British clinical psychologists in any significant way.

The foundations of behaviour therapy can legitimately be considered to extend back before the 1950s (Eysenck, 1960; Eysenck, 1972; Kazdin, 1978) although its pedigree is really nothing like as long as has sometimes been claimed (see: Miller, 1988). Nevertheless, it was Wolpe's work in the 1950s, especially the

publication of his book *Psychotherapy by Reciprocal Inhibition* (Wolpe, 1958), that really brought behaviour therapy to the fore. British clinical psychologists were amongst those who first attempted to exploit the ideas put forward by Wolpe (e.g. Jones, 1956; Meyer, 1957). Both Jones and Meyer were then working at the Institute of Psychiatry and Maudsley Hospital in London and it was from this same setting that H.J. Eysenck founded the first of the many behaviour therapy journals, *Behaviour Research and Therapy*, in 1963.

Behaviour therapy, with its claim to be based on the principles of conditioning and learning, clearly set out an approach to treatment whose general intellectual justification was firmly based in psychology rather than psychiatry. Not surprisingly psychologists generally considered that they, rather than psychiatrists or anyone else, possessed the relevant background training and expertise for the practice of behaviour therapy. Psychiatrists for their part, showed concern about the propriety of allowing non-medically trained personnel to indulge in therapeutic activities.

As behavioural methods became more widely accepted, especially in relation to the treatment of anxiety-related problems and with their applications being extended into work with other client groups such as children and those with learning disabilities, so psychologists also tended to become accepted as the main practitioners of behavioural techniques. By the 1970s, the therapeutic role of clinical psychology was firmly established and any questioning of the appropriateness of having psychologists act as therapists had all but died away.

This movement of psychologists from work centred on psychological assessment to that based on intervention and treatment, not only provided a new role for clinical psychologists, which they very much welcomed, but also helped to distance clinical psychology from psychiatry. Work in psychological assessment left the clinical psychologist to a considerable degree in a secondary role in relation to the psychiatrist. The psychologist might provide useful information about the patient and his or her problems. It was very definitely the psychiatrist who determined the actions that should be taken on the basis of this and other information and dealt with treatment. The fact that psychologists became able not only to assess their own patients or clients but also to institute and carry through treatments, affected the relationship between the two professions. It meant that psychologists not only could, but also did start to practise much more independently of psychiatrists.

This distancing between the two professions had wider implications. The psychologist in an assessment role was to a considerable degree feeding into psychiatric diagnosis and therefore had, to some degree at least, to relate assessment to the working conceptual models of psychiatrists. An independent therapeutic role helped psychologists to emphasise their own psychological models, in contrast to the biomedical models which dominated psychiatry. The anti-psychiatry movement of the 1960s probably also had a greater impact on the thinking of psychologists, and this further contributed to the distancing of the working models and assumptions employed by the two professions.

Having used behaviour therapy to gain a firm foothold in therapeutic activities through the 1960s and early 1970s, clinical psychologists have steadily spread into adopting a wider range of therapeutic models and forms of psychological intervention. Many of these, like the different forms of dynamic psychotherapy and systemic models have little to do with behaviour therapy and do not always

have strong links with psychology as an academic discipline. The one major and more recent therapeutic model which is seen as falling more within the province of psychologists and which has significant links with both psychological theory and behaviour therapy, is that of cognitive therapy (see: Hawton et al, 1989).

Cognitive therapy, as developed by Beck and others (e.g. Beck, 1970), and the so-called 'cognitive revolution' in academic psychology (see: Baars, 1986) have very different origins. The first arose out of clinical practice, whilst the other has its origin in the application of information processing models in human experimental psychology. Despite this, the two developments which originally shared little more in common than the use of the adjective 'cognitive' have come together and influenced one another. In particular, much research relating to cognitive therapy and models which might underlie that method is informed by academic cognitive psychology (e.g. Teasdale & Barnard, 1993).

Whatever the theoretical basis that is employed, a commitment to a form of working which stresses the extensive use of psychological methods of treatment or intervention has now been long established as the major part of psychological practice in clinical settings. It can be noted here that two highly significant figures in establishing and developing the therapeutic role of clinical psychologists have actually been psychiatrists. The first was Joseph Wolpe, whose 'psychotherapy by reciprocal inhibition' or systematic desensitisation became by far the most extensively used behavioural technique. The second was Aaron Beck who has played an important role in the development of cognitive behaviour therapy, as derived from his work on depression (e.g. Beck, 1976), though neither of these was actually the originator of the particular school of therapy with which his name is now strongly linked. Despite this, both have been highly influential in determining both the therapeutic practice of clinical psychologists and thinking about underlying models of intervention.

A major landmark in the development of clinical psychology was the production in 1977 of the Trethowan Report on the role of psychologists in health services (Trethowan, 1977). Apart from affording some recognition of the value of clinical psychology, in that it was an important enough area of work to warrant detailed attention by the then Department of Health & Social Security, this report served other purposes. It affirmed the place of clinical psychology as an independent and autonomous profession as well as legitimising its role in a number of areas of work outside psychiatry, such as primary health care, the neurosciences, and geriatrics. This is not to claim that such developments had not antedated Trethowan, as Zangwill's early war-time work with the brain injured illustrates (Zangwill, 1947). Nevertheless, Trethowan was important in altering perceptions as to what a reasonably comprehensive clinical psychology service should cover.

Also of some importance in the development of clinical psychology within the NHS was the fact that the Trethowan Committee advocated the setting up of separate departments of clinical psychology at an 'Area' level within the then three tiered system of NHS organisation. In fact, this merely legitimised what had already happened in many of the more developed services, although it did aid the spread of this organisational model elsewhere. In so doing, it also contributed to

the further separation of clinical psychology from psychiatry, and confirmed the place of the former as a separate and autonomous profession.

The wider role of clinical psychology was also later confirmed by a further government report (Manpower Planning Advisory Group, 1990). Part of this report drew attention to the shortage of trained clinical psychologists in relation to the apparent needs of the NHS, whilst at the same time arguing for stronger role for the profession. As things have worked out, the work that went into this report was overshadowed by the issuing of the 1990 Government White Paper *Working for Patients* and the stream of 'reforms' introduced into the NHS that have followed in its wake.

Whilst the consequences of these changes are not yet fully clear in terms of the issues being considered here, one outcome has been to break up the then existing District-wide clinical psychology services and to push their organisation back to a much lower level in the system. This has often been at the level of clinical directorates. Many psychologists have seen this as a threat to professional autonomy, and psychologists have not been unique in having this reaction. What it has done is to force many clinical psychologists in the mental health field to be linked more closely with their psychiatric colleagues and thereby to some extent reversing some, but not all, of the earlier trends that pushed the two professions apart. Assuming that present trends continue, the two professions may need to work out yet again a new *modus vivendi*.

Summary and Comment

Clinical psychology in Britain is still a relatively recent and small profession which in many ways still appears to be developing and extending its ways of working. Although recent in terms of its formal establishment, the influences that led eventually to the profession being officially incorporated into the NHS in 1948 have roots that extend back much earlier. The transatlantic influence has always been, and is likely to remain, a powerful factor. Indigenous factors go back to the management of shellshock in the First World War, the industrial psychology of the period between the two world wars, and then the work of the military hospitals and personnel selection in the Second. In the post-war years, clinical psychology has developed and considerably expanded, albeit from an initial base that was extremely small. At the same time, it has also changed in ways that have acted to distance clinical psychology to some degree from its earlier strong links with psychiatry.

In all of this, the fate of clinical psychology has been and is likely to remain quite closely intertwined with that of psychiatry, despite the nature of the relationship having radically changed. Both professions are heavily committed to the field of mental health; one exclusively so and the other predominantly so. Both provide skills essential to the provision of mental health services and also potentially provide articulate personnel with a relatively broad and extensive training. Both are also needed to argue the importance of service considerations in an NHS which is now increasingly dominated by managerial priorities. For the sake of those who depend upon these services, it is important

that the two professions, in collaboration with others, can present a reasonably coherent front.

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II. Professions, Areas and Institutions

10 Mental Health Nursing in Great Britain

PETER NOLAN

Today's historians writing about mental health nursing in the twentieth century find their work appreciated by a far wider audience than would have been the case a few decades ago. This is because nurses have come to acknowledge that their understanding of practical psychiatry is enhanced by exploring the social and therapeutic contexts in which nurses and patients have interacted since the advent of institutional psychiatry. This chapter, which focuses primarily on nursing within the general psychiatric sector, reflects a growing interest amongst all mental health care workers in the influences that have shaped mental health nursing into what it is today.

It is important to appreciate, from the outset, that mental health nursing as a profession is relatively unique and is not an essential component of mental health services world-wide. In Europe, only seven countries, apart from the UK, have separate Professional Registers for psychiatric nurses: – Belgium, Denmark, Eire, France, Germany, Luxembourg and the Netherlands. Elsewhere, only some states of South Africa, Zimbabwe, Australia and Canada have separate Registers whilst in the majority of countries, mental health nursing, if provided at all, is delivered by general nurses with varying degrees of training and expertise. Mental health nursing has not established itself as an international force unlike general nursing which, by and large, has defined itself in similar terms the world over. The result of this is that opportunities for cross-cultural comparisons are limited. Dialogue between psychiatric nurses from different parts of the world is rare so there is little scope for learning from the experiences and practices of other groups (Rawlinson & Brown, 1991). There are few opportunities to set British constructs of mental health nursing against those of other countries and it is because this is so that it becomes especially valuable to inform contemporary practice by looking for comparisons within a historical context.

One of the most fruitful ways of approaching the history of mental health nursing is to try and analyse its development from the perspective of those engaged in it. Histories of mental health care have, to date, tended to describe famous hospitals, doctors, and patients of the last 150 years, but relatively little has been written about the people who have provided care for the mentally ill. They have also tended to be anglocentric and to have given considerably less attention to the development of mental health care in Scotland, Wales, and Ireland. A history of mental health nursing is essentially a history of psychiatry

from the bottom up; unfortunately, material relating to the people who, down the years, have provided day to day care for the mentally ill is not so plentiful as that which tells about the important people at the top of the mental health hierarchy. Mental nurses of the late 19th and early 20th centuries were often illiterate, and few records written by them or relating to their working lives have been preserved. Nor were they a homogenous group, generally espousing similar philosophies of care or engaging in comparable activities. Different institutions had different requirements of the nurses they recruited and drew on different pools of available labour. Asylum workers, particularly in the 19th century, were isolated from each other and had little by way of a shared culture. Yet despite an overall paucity of primary source material, sufficient has come to light in recent years as the archives of psychiatric hospitals destined for closure have been urgently studied, to make a history of mental health nursing both possible and satisfying.

In his presidential address to the Annual Meeting of the Royal Medico-Psychological Association held at Cane Hill Hospital in July 1960, Dr. Alexander Walk reminded his audience of psychiatrists of the 'almost complete neglect of mental nursing in the current histories whether of nursing or psychiatry' (Walk, 1961). He considered this state of affairs regrettable and after providing an overview of the origins and development of mental nursing, entreated future historians to pay more attention to: 'A profession which has had to contend with many handicaps and many frustrations, but whose splendours far outshine its shortcomings. Sometimes we (psychiatrists) are able to think of its members as our sweethearts or wives; all too rarely they are our sons and daughters; but always they are our friends and allies.'

It is likely that Walk's lecture was at least partly inspired by a paper of Hunter's (1956), in which he strongly denounced the traditional stereotype of the mental nurse as indolent, routine-dependent, and devoid of compassion. Hunter argued that Britain had led the world in humanising attitudes towards and care of the mentally ill, and that the embodiment of this humanistic approach was to be found in the work of mental nurses. Almost 20 years after Walk's speech, Carpenter (1980) was still asking why so little attention had been paid to the history of mental nursing, in contrast to the 'almost insatiable public interest in the lives and work of general nurses'. Answering his own question, he remarked that a society which rejected the mentally ill inevitably marginalised those who cared for them and that 'the men and women who nurse the mentally disturbed seldom achieve public attention except as a result of scandal or a case of alleged ill treatment. Public interest in psychiatric nursing, if displayed at all, invariably focuses on the sensational.'

In the 1980s, a widespread demolition of psychiatric hospitals began and although many records were painstakingly preserved and are now on public display, others were lost or destroyed. Spurred on by this threat to the integrity of the mental health archives, historians began to rethink the history of psychiatry and to embrace nursing as an integral part of it. New efforts were made to understand and record the part which nurses had played in the history of psychiatric care and to reassess the collaboration between doctors and nurses. Russell (1983) concluded in his study of a North of England asylum in the 19th century that asylum nurses, far from being peripheral to the system and its aspirations, were essentially its backbone. Though they possessed little power to

determine how the institutions were managed, yet they exercised immeasurable influence over patients' lives. Re-examining primary source material at The Retreat in York where humane treatment of the insane was pioneered, Digby (1985) found that nursing was the 'hidden dimension' of its success. In recent years, Andrews (1991) has shed new light on the centrality of the work of the attendants and nurses at the Bethlem Hospital, while Carpenter (1988), Nolan (1993), and Clarke (1994) have further added to the growing body of literature.

Pioneers of 'Moral Management'

In tracing the history of mental health care, Walk (1961) acclaimed the work of religious organisations such as the Order of St. John of God and the Sisters of Charity in the middle ages in campaigning throughout Europe for a compassionate approach to the care of the mentally ill. He noted that members of the Augustinian Religious Order administered and staffed the enormous 'Hotel-Dieu' hospital in Paris from the 9th century onwards as well as the nearby St. Louis Hospital from 1607. Weiner (1979, 1988) agrees that nursing was solidly entrenched in European hospitals long before medical schools first appeared in the universities. Searching for the secular founders of mental nursing, she looks to the moral treatment era of the late 18th and 19th centuries and to Pinel, Pussin, and Tuke in particular, but reminds us that these men were not the only 'enlightened liberators of the age' and that the contributions made by Willis, Haslam, and Fowler in Scotland, by Daquin at Chambery and Chiarugi in Florence, and by the French military Medical Inspector, Jean Colombier, should not be overlooked. The life and work of Philippe Pinel are a microcosm of the way in which care of the mentally ill by the great religious orders was gradually passed over to secular authorities, as the profession of medicine became established. Philippe Pinel was the son of a Parisian doctor; at an early age, he entered a monastery to study for the priesthood, but left after only three years with a mission to place his skills and energy at the service of the mentally disordered (Breathnach, 1994). He was strongly influenced in his approach by the ethos of the famous religious hospital of Zaragoza, founded in 1425, where outdoor labour and structured activities were noted to be highly therapeutic for the disturbed mind (Weiner 1988).

The work of Pinel at the Bicêtre in Paris and of his Chief Nurse, Jean Pussin, were reflected in England in the religious and humanitarian enterprise of William Tuke who, in 1796, founded The York Retreat for the care of the mentally disordered. The change-over from religious to secular care which occurred in the late eighteenth century is clearly apparent in the ethos of the Retreat, which grew out of the Quaker faith. Day-to-day management of patients aimed to include them within the framework of civilised society, rather than excluding them. The Retreat's recruiting policy was to select only staff who shared the Quaker faith and could empathise with the declared aims of the institution (Digby, 1985). Within a very short time, it had gained an international reputation and was receiving eminent visitors from abroad, such as Dr. Naudi, President of the Maltese Hospitals, who commented,

This house or retreat for the troubled in mind, I think, is one of the best things I saw in England; and having observed many others on the continent, I dare to say it is the best in all the world. The situation of the building out of town, a large garden around it, the propriety of the rooms, the cleanliness of the patients, the way in which they are kept as for dressing, as for feeding them, is very remarkable to be observed. (Tuke, 1882, p.123)

The atmosphere and environment which Naudi is here describing were largely attributable to the work of George Jepson, a respected figure in the local Quaker community and a faith healer (Jones, 1983). Jepson was appointed as Superintendent of The Retreat shortly after its opening (Digby, 1985). Although he had had no formal experience of medicine or nursing, Tuke recognised in him 'a steady religious friend' and a person who could steer The Retreat according to the principles which Tuke himself espoused. In April 1797, Catherine Allen came to The Retreat from Bristol, where she had worked at Dr. Edward Long Fox's madhouse, another Quaker establishment, and was appointed Matron for the female patients. She and Jepson married soon after: 'Catherine Allen's warmth of personality, compassion and dedication won the gratitude and admiration of her patients and their families. With the fortunate appointment of Jepson and Allen, the domestic organisation of The Retreat was assured of humanity and efficiency until their retirement in 1823' (Digby, 1985).

The work of Jepson and Allen became a model for progressive private institutions such as Dr. Nathaniel Cotton's mad-house near St. Alban's. Here, the poet, Samuel Cowper, who suffered from chronic depression, spent many months receiving care. Cowper (1816) noted that it was a combination of the kindness of the staff (and especially of his personal attendant, Sam Roberts), and of the tranquillity of the carefully tended garden that helped him to regain his sanity. Other private institutions which followed the example of The Retreat were Brislington House near Bristol and Ticehurst in Kent. Great care was taken in the selection of staff for Ticehurst where, in return for the delivery of high standards of care, they enjoyed excellent pay and working conditions:

Attendants could take two weeks holiday a year; and married attendants were allowed to sleep at home. Although unmarried attendants generally slept in the room of the patient for whom they were responsible, male attendants were allowed three hours of relaxation every day, and female attendants 'short periods' of relaxation two times a week and one full day a month. Job satisfaction, relative to other employment opportunities locally, was reflected in a low staff turnover, particularly on the male side, where wages were the highest. (MacKenzie, 1992, p.144)

Unfortunately, the standards adhered to at Ticehurst did not hold in many other private madhouses which remained untouched by the influence of The Retreat. Dr. John Haslam's (1809) book, *Observations on Madness & Melancholy*, describes how the attendants or keepers employed in some private institutions provided very poor care:

With respect to the persons, called keepers, who are placed over the insane, public hospitals have generally very much the advantage.

They are better paid, which makes them anxious to preserve their situations by attention to good behaviour: and thus they acquire some experience of diseases. But it is very different in the private receptacles for manics. They procure them at a cheap rate: they are taken from the plough, the loom, or the stable; and sometimes this tribe consists of decayed smugglers, broken excise-men, or discharged sheriff's officers. If anything could add to the calamity of mental derangement, it would be the mode which is generally adopted for its cure.

The 1815 Parliamentary Inquiry into madhouses found much to condemn in both the private and the public sectors, with violent patients often being accommodated with non-violent and very low attendant/patient ratios. In 1828, legislation was passed which aimed to improve service to the mentally ill by requiring that every asylum of 100 beds or more employ a resident apothecary. His job was to ensure that patients received a proper diet, had access to facilities for the maintenance of personal hygiene and were provided with good nursing care (Crammer, 1994). He had also to treat the numerous physical ailments with which any population inhabiting a mental institution could expect to be afflicted. Meanwhile, the number of people identified as being mentally ill was steadily increasing: the 1844 Report of the Metropolitan Commissioners in Lunacy stated that the figure was almost six-fold that reported in 1807. The Commissioners concluded that the time had come for government to initiate a national programme of asylum building, the cost of which would be met at local level.

Scotland

The history of mental health care in Scotland has hardly been attempted (Walmsley, 1991) and what follows relates only to the Royal Edinburgh Asylum (REA) which, because of its size and importance retains detailed records. The REA was founded in 1813 with the declared intention of providing the highest standards of care for mentally ill patients. Jane Upton MacDonald was its first Matron, and her nursing skills and immense compassion for patients 'lay the foundations upon which her successors . . . successfully built' (*A Hospital Comes of Age*, 1963, p4). In order to help the attendants understand their duties, she devised a Rule Book, perhaps the earliest example of a professional manual for mental health nurses. While she was in charge, no distinction was made between care of the 50 wealthy patients in the East House and the 500 lower middle class and pauper patients in the West. On her death, however, two Matrons were appointed to replace her, one to each House: 'It has been proposed that the Matron of the East House should be a person of a superior class, capable of acting as a friend and companion of the female patients and at the same time qualified to discharge the duties of Housekeeper of the establishment. The duties of position of Matron in the Western department, though equally responsible and more laborious, will require qualifications of a somewhat different kind' (Vol. 3, p.167).

The Matron of the East House received £50 per annum, while the one appointed to the West House received £60, despite undertaking less 'laborious' duties. Thus it was that a distinction between the care of wealthy and pauper

patients was introduced at the hospital, and the qualifications required of managers were based on class.

Recruiting attendants was as difficult in Scotland as in England with 'undesirable and ill-motivated candidates (being) attracted' to the work (Macdonald, 1993). Hobbeling (1993) concludes that there was also a major problem in retaining staff. The reason for this may be deduced from the Annual Reports of the Royal Edinburgh Asylum which, despite their compassionate rhetoric, cannot entirely conceal the harsh regime under which staff were expected to care for patients and the way in which they were not cared for themselves. The '*General Instructions to the Attendants*' of 1842 insisted on 'order, quietness, punctuality, personal neatness and general propriety', and any transgression was to be punished with fines and often with instant dismissal. Attendants were expected to sleep on the same wards as the patients at night because, in the opinion of the Medical Superintendent, Dr. MacKinnon: 'The presence of the attendant in the same room with the inmates keeps up that moral restraint during the night which is exercised with benefit during the day' (1842, p.20).

In essence, attendants were on duty 24 hours a day, with the requirement to sleep on the wards ensuring that staffing levels were sufficient to maintain control of patients at all times.

Ireland

Mental health care in nineteenth century Ireland was provided on a far more ad hoc basis than in Scotland or England. This was a reflection of the largely unorganised nature of poor relief, with care of the poor and the insane falling largely upon the parishes and the families of the sufferers (Finnane, 1981, p.23). In 1807, there was just one private madhouse, located in Cork, to serve the entire country, as compared with 45 private madhouses in England. Conditions in the public asylums were harsh with diseases related to overcrowding rife. Rapid turnover of staff resulted in disruption to asylum routines and to the quality of care provision. Staff left either because they found asylum work dangerous and unpleasant or because they were paid insufficient money to allow them to save for emigration. In the mid-19th century, a male attendant's wages were between £7 and £10 per annum and a female attendant's between £4 and £6. This was considerably less than the wages of their counterparts in England or Scotland or than those of farm labourers who earned between £8 and £12 per annum. Nevertheless, it was acknowledged that there were advantages in having attendants and inmates in the public asylums coming from the same social class and some Inspectors remarked on 'the kindly and familiar relationship existing in Irish asylums between the inmates, lunatics and servants alike' (Finnane, 1981, p.179).

A particular insight is provided into later Irish asylum care in a report to the Irish Division of the Medico-Psychological Association in Mullingar in 1892, where Dr. Arthur Finegan described the obstacles that prevented the training of attendants in Ireland after a new national training scheme had been inaugurated in England. The heavy workload shouldered by the small number of qualified doctors made it difficult for them to provide lectures for attendants, and that once trained many attendants would, Dr. Finegan suggested,

immediately leave and try to better themselves in England. Despite his doubts about training, Finegan was nevertheless one of the first doctors to offer classes to Irish attendants based on *The Handbook for Attendants upon the Insane* (Journal of Mental Science, 1892, p.317) and instituted the 'Finegan Prize' which was awarded annually at the Mullingar Mental Hospital from the late 1890s until the early 1960s. At his own request, he was buried in the patient's graveyard, where his memorial now takes pride of place.

A New Era in Mental Health Care in Britain

The Lunacy Act of 1845 was a milestone along the road of mental health care in the British Isles. Its architect was Lord Shaftsbury who had long campaigned for a radically new approach to the care of the mentally ill, based on the principles of The Retreat; he saw the creation of a national network of asylums as synonymous with improved care. Despite his clearly genuine humanitarian concern, the debates he initiated in Parliament looked in detail at the management and funding of the asylums, and at the role of medical superintendents, but made no mention of the work of the attendants (nurses) who would be in contact with the patients on a day to day basis. The number of nurses required to staff the new institutions, and the qualities and skills they would need in order to be effective in implementing 'moral management' of patients were never considered.

Once opened, the new asylums were almost immediately overwhelmed by large numbers of ex-workhouse inmates suffering from a variety of chronic, often mainly physical, illnesses and, within a short period, over 90% of the asylum population was classified as paupers (Korman & Glennerster, 1990). The asylums were expected to be largely self-supporting, feeding staff and inmates from the produce of their farms and keeping labour costs to a minimum. This meant that staff had to undertake a wide variety of tasks as explained in the 1851 Medical Report of the Worcester County Asylum:

Most of the attendants are artisans who work with the patients, do all the repairs and anything requiring attention. The shoemaker takes chief charge of the First Male Convalescent Ward as well as overseeing the shoe-repair shop. The mason takes charge of the Second Convalescent Ward: he is glazier, painter and decorator. The tailor assists in the Fourth or Epileptic Ward at meal-times and in the evenings. The Fifth Ward has two attendants: the junior takes charge of the barrow-men and assists in all excavations and wheeling of earth. It is only by such arrangements that any asylum can be conducted efficiently.

Hunter & Macalpine (1974) described the work of Victorian attendants as cleaning, bed-making, dressing patients, serving meals, and supervising patients in the airing courts and at work on the farms and in the gardens. Of the 75 patients who died at Colney Hatch Asylum in 1859, 36 had been bedridden, paralysed, and helpless for months (Hunter & Macalpine, 1974) and as the numbers of heavily dependent patients increased with the influx from the poorhouses, it became ever more difficult to recruit suitable nursing staff. Robertson (1861) noted that at the West Riding Asylum one Medical Superintendent dismissed 91 of the workforce of 567 attendants during his term

of office for reasons ranging from dishonesty to being drunk on duty. Staff at the Lancaster Asylum remained for an average of nine months only before leaving to find more lucrative employment elsewhere (Nolan, 1993).

Carpenter (1988) contends that poor pay and working conditions were largely responsible for the failure of the asylums to attract good quality staff, and that the effect of the continuous and rapid turn-over of attendants was to prevent the vigorous development of nursing skills which could inform patient care. Staff working in the asylums were not able to benefit from communication with each other, as the asylum system was a very loose alliance of institutions which had little contact with each other. It was not until a national training scheme for attendants was initiated at the end of the nineteenth century, and the first strikes took place in the asylums at the beginning of the twentieth, that attendants began to assert themselves as an integrated workforce aspiring to become a profession.

Training for attendants lagged far behind that of doctors, for whom some provision had been made since the 1820s. Alexander Morrison started in-house lectures for doctors at the Bethlem Hospital in 1823, John Connolly at the Hanwell Asylum in 1842, and Thomas Laycock in Edinburgh in the 1860s. However, it was not until 1885 that the Medico-Psychological Association, under the aegis of the General Medical Council, set up a national scheme for doctors, leading to the Certificate in Psychological Medicine (Lewis, 1967). Informal teaching of nurses by the newly qualified doctors then became increasingly widespread and, in an effort to improve both the prestige of asylum nurses and the standard of their work, Henry Maudsley suggested that a Register of 'good attendants' should be established to encourage better candidates to come forward for nursing (Adams, 1969). In 1885, the Medico-Psychological Association published a book which aimed to help attendants 'to a due understanding of the work in which they were engaged' (Rollin, 1986). This was *The Handbook for the Instruction of Attendants on the Insane*.

According to this handbook, the first requirement of an attendant was personal discipline and to set an example to the patients of industry, order, cleanliness, and obedience. There were chapters covering general functions of the body, aspects of nursing the sick, the mind and its disorders, care of the insane, and the general duties of attendants. The effect of its publication was very much to heighten awareness of the need for a national training programme for attendants; it drove the Medico-Psychological Association to announce at its Annual General Meeting in Glasgow in 1890 that such a programme would indeed be inaugurated. The new training scheme aimed to provide attendants/nurses (the two names were becoming interchangeable) with a good grounding in anatomy and physiology and to help them acquire skills in 'first aid'. Examinations were held on the first Mondays of May and November and successful candidates were entitled to use the letters MPA after their names. Thirty-five candidates, 20 female and 15 male, presented themselves for the first examination in May 1891; they came from Rubery Asylum in Birmingham, James Murray's Royal Asylum in Perth, Kirklands Asylum in Bothwell, and Stirling District Asylum in Larbert. All were successful. By 1899, 100 asylums were participating in the two-year training scheme, which was extended to three years in 1908 (Carpenter, 1988, p.32).

Whatever were the aspirations of nurses newly qualified under the MPA scheme, they were quickly dashed by the stark reality of the situation in the

asylums. Having a qualification did not improve the status of those who held it, their income, or their promotion prospects. Nor did new government legislation in the form of the Lunacy Act of 1890 do anything to further the development of mental nursing (Clarke, 1994). The Act required that all patients be certified on admission, with the result that access to the asylums was restricted to those with severe mental illness. As the clientele of the asylums changed from a mixture of patients with a wide variety of both physical and mental ailments to consist more of people with far-advanced and florid mental illness, nursing became primarily a job of controlling inmates, maintaining order on the wards and managing large numbers of very seriously ill people as efficiently (not necessarily as humanely) as possible. The position of qualified nurses was exactly the same as that of the untrained attendants.

Such a situation was intolerable and as the availability of the Handbook and increased uptake of the national training scheme brought greater unity amongst asylum nurses, so their political awareness grew. Staff at some hospitals began to ask for better pay and conditions, and growing discontent in all areas of the country culminated in the founding of 'The National Asylum Workers' Union' (NAWU) in Preston on the 24th September, 1910, a Union run by nurses for the advancement of nursing. In January, 1918, the NAWU presented its demands to the Lancashire Asylums Board. These were:

- 1 A permanent increase in wages of 5 shillings per week for all staff
- 2 Weekly payment of wages
- 3 An increase of a halfpenny an hour for all artisans, labourers and stokers
- 4 A 60 hour week with overtime paid at the rate of time and a half
- 5 Discontinuation of the practice of retaining a month's wages in hand
- 6 Payment of one shilling and six pence a night for married men sleeping in the asylum
- 7 An award of £2 – 10s to nurses on passing the MPA's examination
- 8 Permission to post Union notices in mess rooms
- 9 Weekly posting of dietary lists in the mess rooms.

The Board accepted only the first of these. Relations with the attendants became increasingly fraught thereafter and culminated in a series of strikes by asylum staff, the first of which were at Prestwich, Whittingham, and Winwick asylums on the 4th and 5th September, 1918, with over 200 staff involved (Carpenter, 1985).

The First Mental Hospital Enquiries

After the First World War, there was further rapid expansion of the mental hospital population as numerous casualties from the battlefronts were admitted. The limited skills and resources to which mental nurses could lay claim in dealing with the acute distress of the soldiers were thrown into stark relief. Montagu Lomax's post-War book (1922) which tells of his experiences as a doctor at Prestwich Asylum criticised both the lay and medical management and accused nurses of being without tact, patience, sympathy, or understanding.

These failings were only superseded, according to Lomax, by those of the Medical Superintendents, whom he described as irresponsible, vain, lazy, unjust, mean, and tyrannical. Although Lomax's allegations were not, for the most part, upheld by an internal investigation at Prestwich, there is no doubt that his book was largely responsible for the first official Enquiry into mental nursing in England, which reported in 1924 under the title of 'Nursing in County and Borough Mental Hospitals'.

This Enquiry recognised that mental nurses needed a wide range of skills in order to look after patients who were often both mentally and physically ill. In order to recruit and retain staff of the right calibre, it recommended improving recreational and educational facilities, but was forced to recognise that building up a high-quality mental nursing workforce would require considerable expenditure, and that the economic climate of post-War Britain could not ensure proper staffing levels throughout the country's asylums. Nonetheless, the Enquiry urged asylum managers to be vigilant in improving standards, and recommended the integration of mental nursing into the wider field of general nursing, where standards of good practice were already well established.

The unrest amongst mental nurses and the problems facing the asylums were not helped by a further conflict which sprang up between the newly formed General Nursing Council (GNC) and the Medico-Psychological Association (MPA). The GNC had been established as a result of the Nurses' Act of 1919, and quickly put winning sole control of mental nurse training at the top of its agenda. In order to accomplish this aim, the GNC set up its own training programme for mental nurses in opposition to that provided by the MPA. The GNC's programme led to the qualification of Registered Mental Nurse (RMN) and the first candidates sat its examination in 1922 (of the 161 who passed, 113 were women). From 1922 until 1951, the GNC's and MPA's training schemes ran side by side, and this sowed dissent amongst mental nurses, who were naturally confused as to which training they should follow. The GNC claimed that its course was nurse-centred and sure of being relevant because it was taught by nurses; the MPA claimed that its course was based on the pathology of mental illness and the treatment of patients and was superior because it was taught by psychiatrists. Since it was still far from clear as to what mental nurses were being trained to do in the asylums, the disagreement between the GNC and the MPA was, for a long time, insoluble. It was not, in any case, a debate about the fundamentals of good practice in mental health nursing, but rather a dispute about professional boundaries. Both the MPA and the GNC ignored the urgent need of mental nursing to define its role more clearly, while the situation within the hard-pressed asylums became ever more critical.

The 1920s and '30s

After the First World War, the asylums, still plagued by a high turnover of nurses, were glad to welcome onto their staff large numbers of demobilised service men seeking work during the economic depression of the 1920s. These were not people who chose nursing as a vocation, but individuals who could not find anything 'better' to do. Tom Hopkinson was one such ex-service man who was helped by the British Legion to get work at Rubery Hill Hospital in

Birmingham in 1923, after spending five years in the Navy (Hopkinson, 1994). He was aware of the prejudice in the local community towards the patients and knew that local people referred to the staff at the hospital as 'lion-tamers' or 'loony-tamers', and admitted in his memoirs to being 'really scared on my first day at work'. Rubery Hill had, at this time, an average of 60 patients per ward, most of whom were 'unclassified', meaning that they had no diagnosis. Many had had been delivered to the main entrance of the hospital by police officers who had found them wandering in the streets. Nursing staff at Rubery Hill worked a 60-hour week with overtime twice a month to provide emergency cover, had Sunday off approximately once in every three months, and could expect to have Christmas Day at home once every six years. All new staff served a six months probationary period after which they could choose to do their training, but all lectures had to be attended in their own time: 'I took a keen interest in the lectures and I even bought a copy of the Handbook. In the final exam, I managed to get a distinction in two subjects and when one of the junior doctors came to the ward some days later, I told him what I had achieved and he told me, "Forget it". I felt very disappointed that a doctor should consider the training programme in such a way' (Hopkinson, 1994).

The newly qualified Nurse Hopkinson was not impressed by the medical staff, finding the high-handed attitude of the Superintendent different from anything he had experienced in the Navy. Patients and staff were frequently shouted at and publicly humiliated; it was impressed upon him that he should be grateful to have a job and that unquestioning and uncomplaining compliance with the routines and protocols of the asylum was expected. Hopkinson noted that the staff rapidly became as institutionalised as the patients. Since the Superintendent would not allow meetings of the Asylum Workers Union in the hospital, Union members met in one of the workshops in the hospital grounds. Frequently, the Head Attendant would come in during the meeting; his presence signalled the immediate end of proceedings, as staff were too frightened to talk freely in case he reported back to the Superintendent.

The treatment of patients, as Hopkinson recalled, fell short of what he had expected. Each one had to have a bath once a week, but only the lucky first enjoyed clean water as up to 20 patients were bathed in the same water to cut down on heating expenses. While the Superintendent insisted that all floors and steps should be cleaned with hot water, patients were allowed only cold for their daily wash. Throughout the 1920s and 1930s, the work of the mental nurses serviced the well-being of the institution rather than that of the patients. A female nurse remembers:

When I first started, I worked on what was called a 'sick ward'. The patients were generally elderly and some were very frail. Many had respiratory and coronary diseases and should have been in a general hospital. . . . When we came on duty in the morning at 7.00am, we got as many patients up as we could and washed and dressed them. The rest were left in bed. After breakfast, we swept the dormitory and dayroom floors thoroughly and waxed them. It was my job to 'bump' the floor until it was shining because I was considered big and strong. That took all morning and often there was only half an hour to see to the patients before they were given lunch. Nursing effectiveness was judged by the state of the ward and not the state of the patients. (Reagan, 1994)

A 'good' mental hospital was one with effective security regulations in place to ensure that no patients escaped (Dingwall et al, 1988). Repressive regimes encouraged nurses to see every patient as a potential escapee or suicide case and to take their role as custodians very seriously (Clark, 1956). Their duty 'to be of assistance to the doctor' (Fisher, 1948) centred on keeping the patients under observation so as to be able to report changes in their condition. Nurses were never allowed to forget that their work was, in itself, insufficient without 'the strong right arm of treatment' provided by the medical staff.

During the 1920s, employment within the mental hospitals often had dynastic overtones with a considerable number of male attendants and female nurses coming from families who had found work in the asylums through several generations. Medical superintendents tackled the difficulty of recruiting staff by encouraging parents to bring their children into asylum work. One nurse at the Wiltshire County Asylum recalls:

It never occurred to me that I would do anything else; it seemed inevitable. Ever since I was small boy, my father had been telling me stories about what happened up at the asylum. He was Deputy-Head Attendant and it was his job to ensure that all the doors were securely locked each evening. On summer evenings, he used to take me with him and leave me in the Porter's Lodge while he did his rounds. I remember sitting in the big wooden chair with the Head Porter who was a kindly man and looking round at all the hooks on the wall with shiny bunches of keys and a whistle hanging from each of them. (Newman, 1985)

This nurse also remembers how two patients came regularly to dig his father's garden and how his mother gave them tea and tobacco, welcoming them into her household so that her son never thought of them as odd or dangerous. When he himself joined the hospital staff, he found the environment already familiar and settled in quickly. His first placement was on a 'colony ward' of 63 epileptic patients, where he became accustomed to periodic outbursts of violence and noted how some of the staff responded roughly to the patients, but the majority were compassionate and friendly. One 'staff man' would sit for hours in largely silent companionship with a young male epileptic patient and help him compose a weekly letter to his mother, who lived some distance away. These letters maintained the only link this patient had with the outside world, as his mother explained: 'The reason I keep coming to visit him despite the fact that he says so little to me is that I know from what he writes that he thinks the world of me, and deep down he loves me very much.'

Another nurse who began his career in 1924 and finally became a Chief Male Nurse, recounts how he first entered the asylum one winter's evening through the back entrance. He had been instructed never to use the front entrance, which was reserved for the superintendent, his family, and other important visitors. A porter in a splendid uniform greeted him and took some details before weighing him and directing him to the staff mess-room, where he was given two slices of bread and margarine and a piece of cheese. He was then taken to a small bedroom which adjoined one of the wards:

At about ten o'clock the lights went out and some minutes later, the door opened and an attendant came in, obviously the worse for drink.

He started swearing and shouting at me and told me to get out of his bed. I was so scared, I jumped out of the bed and got into the other immediately and just as I was settling down, I heard him collapse on the floor. When I awoke in the morning, he was still on the floor and had obviously spent the night there. (Lake, 1985)

Shortly after this dramatic induction into asylum life, Ted Lake was asked to consider training and told that he could take either 'the Doctors' Course or the General Nurses' Course'. He reached his decision simply by enrolling on the first available course, which happened to be the GNC's and led him to the qualification of RMN. He was trained by a Sister Tutor who was a general nurse with no experience of mental nursing; she visited the asylum only to teach and then returned to her general hospital. She illustrated her talks solely with examples taken from general nursing. The most participative aspect of the training involved learning how to lay up trays and trollies: 'We spent hours preparing for cold compresses, hot compresses, intubation, stomach lavage and enemata. We had to know every instrument and what its function was, who invented it, when it was invented and its uses and drawbacks.'

The course consisted mainly of anatomy and physiology, which were learned from books and wall charts; little or no part of the course content was of relevance to nurses working with mentally ill patients. After obtaining his RMN qualification, Ted Lake found that in his asylum, only those nurses holding the MPA qualification got promotion, so he started training again. Because he already had his RMN, he was allowed to take the MPA's qualification in one year. This time, he received lectures mainly from medical staff, often the superintendent. The content was more immediately relevant to his work as he learned about mental disorders, how to deal with aggression and violence, and the importance of keeping patients busy. Lectures were usually offered in the evenings in the superintendent's office and if any nurse started to fall asleep (after 12 hours on duty), all the students were made to stand up until the session was completed.

New Forms of Care for Mentally Ill Patients

As the limitations of institutional care became ever clearer during the years between the Wars, a more socially orientated approach to psychiatry started to make headway outside the asylums. The Tavistock Clinic, opened in 1920, was run by a group of doctors and inspired by the work of Freud; here, the institutional basis of psychiatry was rejected in favour of treating mentally ill people in the community. In 1924, the first psychiatric teaching hospital in Britain, the Maudsley, was opened and the Mental Hygiene Movement was founded in the same year. This Movement advocated a programme of health education and disease prevention which started with safeguarding the health of the pregnant woman, and then following her child through adolescence into adulthood with the aim of detecting the early manifestations of mental illness. It also aimed to explore the conditions and circumstances which gave rise to mental illness.

Unfortunately, mental nurses took no part in any of these innovations in the care of the mentally ill, remaining strictly confined within the institutions. Their

profession was still insufficiently well defined or rewarded to be able to attract highly motivated and educated people into its ranks. The Second World War, however, offered them the chance to gain new skills outside the institutions. A more liberal, exciting and progressive form of mental nursing developed at Mill Hill Emergency Military Hospital – a boarding school in north London taken over for the care of wounded soldiers returning from the front. Annie Altschul had just completed her general training when she went to work there:

The atmosphere at Mill Hill was refreshing. . . . I found an excitement about the work that I had not encountered before. Everybody was expected to make a contribution. The staff, both doctors and nurses, were very keen to learn and every patient was regarded as interesting and someone from whom we could learn a lot. I worked with people I had only read about until then: Dr. Maxwell Jones, Dr. William Sargent and Dr. Emmanuel Miller, and each of them made a considerable impression on me. There was no training system as such, just interesting lectures. (Altschul, 1991)

At the beginning of the War, mental nurses under the age of 28 years were asked to volunteer for the armed services and as the War progressed, many were called up. During their induction, they underwent intensive training in emergency nursing – a training which was far superior to that provided in general civilian hospitals. By the end of the War, the mental nurses who had served in the Royal Army Medical Corps were far more skilled and knowledgeable than the average nurse who had never moved out of the institutions, and they had developed leadership skills which were greatly needed by their profession. The considerable contribution made by these nurses to the development of mental nursing is still waiting to be written, but in general it can be said that many attempted to use their newly acquired skills to enhance the practice of mental nursing and its status vis-a-vis general nursing.

The 1950s

During the 1950s, there was a growing awareness that the organisation of the mental institutions might in itself be pathogenic; the influence which had begun at Mill Hill during the War spread more widely. Clarke (1994) notes that a new ethos of care became apparent, characterised by greater interaction between nurses and patients and more liberal regimes such as the open door and week-end leave. Doctors and nurses who were veterans of the War introduced new practices which significantly affected the development of mental health nursing. Innovators in care such as Tom Main at the Cassel Hospital, David Martin at Claybury, and David Clark at Fulborn demonstrated that new therapeutic ideas could result in significant improvement in even the most seriously ill of patients.

Cameron & Laing reported on the transformation of the Glasgow Royal Mental Hospital when it was recognised that the relationship between a nurse and patient did not have to be one of custodian and detainee, but could be developed as a therapeutic tool. Nurses were allocated to care for the same patients each day and encouraged them to read, talk to each other, and do things for themselves.

After a short period, the morale of the patients was immeasurably improved: 'They paid attention to their appearance and some began to sew, draw, or make rugs. Most of them took over small jobs which they jealously insisted on doing for themselves. Thus, at tea-time, one patient made the tea, another laid out the cups, a third put the sugar on the table, another the milk, yet another spread the table-cloth and so on' (Cameron and Laing, 1955).

Unfortunately, despite such clear evidence that new approaches could play a major part in the recovery of patients, nurses were often resistant to change (Clarke, 1994). Where revitalisation of the institutions did occur in the 1950s, it was often attributable to nurses who were sufficiently farseeing to appreciate the significance of new psychiatric drugs such as chlorpromazine. Hunter (1956) argued that this was highly significant in the development of mental nursing, not for its therapeutic properties, but because of the apprehension to which it gave rise that it would make nurses redundant or at least into a different kind of health professional.

During the 1950s, the government became concerned about the costs of providing a universal health service, free at the point of delivery. Responses to escalating costs included reducing the overall numbers of staff and recruiting only untrained people to fill vacancies. The mental hospitals were made receptacles for large numbers of geriatric patients, just as, 100 years previously, they had been used for patients with chronic illness, whether physical or mental. Nursing morale was inevitably not improved by this increase in long-stay patients who could never be expected to leave the institution. Increases in wages might have gone some way to improving morale, but the structure of nurses' pay-negotiations was complex and successfully diluted the power of the Confederation of Health Service Employees, COHSE, which now represented nearly all mental health workers (Carpenter, 1988). Nor was COHSE entirely wholehearted in its support of mental nurses who did not attract the sympathy of the public in the same way as general nurses. Standards of mental nursing in the psychiatric hospitals fell when psychiatric units began to be set up within General Hospitals, which tended to cream off the more able nurses, some of whom were replaced by auxiliaries – a situation which accelerated the deskilling of the workforce left in the psychiatric hospitals.

A Royal College of Nursing conference held in 1954 discussed the problem of low morale in the mental nursing profession, and heard that up to 80% of entrants left before completing their training (Nursing Mirror, 1954). Job satisfaction was poor because of overcrowding in the hospitals, the large percentage of patients labelled as 'incurable', lack of cooperation and respect between doctors and nurses, and management hierarchies which devalued nursing. The conference heard that training was largely irrelevant to practice, as many tutors had no experience of nursing the mentally ill. Recommendations were made that:

- 1 Mental nursing and general nursing should be amalgamated
- 2 The age of entry to mental nursing should be reduced to 17 ½ and the upper limit raised to 60
- 3 Teaching of student nurses should take place in small groups
- 4 More cooperation should be sought between doctors and nurses and between tutors and clinical staff

- 5 Psychology and sociology should be introduced into the training syllabus to help nurses understand the broader needs of mentally ill people and to increase nurses' confidence to provide care outside hospital settings.

The conclusion of this conference was that there was an urgent need for a radical reassessment of the training and work of mental health nurses. A similar conclusion was reached by the Liverpool Regional Hospital Board's Report, also of 1954, entitled 'The Work of the Mental Nurse' and by the Manchester Hospital Board's 1955 publication of the same title. These Reports recognised that mental nursing was a complex activity, difficult to define, but noted that some aspects of its current practice had only the slenderest claim to be related to patient care. They pointed out that the work of the mental nurse could be, and often was, undertaken by untrained nursing assistants and questioned whether this was appropriate. According to Gallagher et al (1957), untrained staff tended to be authoritarian and inclined to distance themselves from patients, assuming a controlling rather than an enabling role. Menzies (1960) did not consider it surprising, however, that staff who had received little or no training to help them cope with the despair and confusion of many patients' lives should retreat into bureaucratic activity and routine tasks in order to protect themselves.

The Expert Committee on Psychiatric Nursing (1956) set up under the aegis of the World Health Organisation highlighted again the long-standing problems of how to define the role of mental nurses and what kind of training best fitted them to care for mentally ill patients. The Committee felt that nurses would move away from their institutional base and be empowered to initiate changes in psychiatric practice, only if they were better educated and trained.

The 1960s to the present day

By the end of the 1950s, there was a growing awareness amongst mental health nurses that their unique contribution to psychiatry would only be recognised and valued by the nursing profession and society at large if they could state exactly what that contribution was. Attempts were made to analyse their work (Maddox, 1957; John, 1961). This was acknowledged to have diverse aspects, but was felt to centre fundamentally on good communication, although nursing researchers noted that much of the care being offered to patients in psychiatric hospitals was non-individualised and task-orientated, and that communication between members of staff and between nurses and patients was generally poor.

Despite the increasing body of evidence that psychiatric nursing was far more about communicating with patients than 'doing' things to them, the GNC took the decision in the early 1960s to second mental nursing students to general hospitals for several months during their training in the belief that this would make them into more flexible practitioners. However, the government's Report 'Psychiatric Nursing Today & Tomorrow' (1968) considered that such work experience probably made them *less* flexible in their response to mental patients. Martin (1968) deplored the failure to help mental nurses acquire the skills which their work specifically required:

Nurses are well trained in the technical aspects of nursing and in the

formal etiquette, but little or no help has been given in the past in the understanding and management of human relationships. And yet, this is probably the most essential qualification for the modern mental nurse. Without such training, nurses have constantly to fall back upon a rigid authoritarian system in order to maintain their security and status. They need the authority of the institution in order to clarify their dealings with their patients.

Ongoing confusion about the role of mental nurses and about what constituted an appropriate training for them, low morale, low pay, and poor working conditions within the psychiatric hospitals erupted finally in the public enquiries of the 1960s and '70s and the exposure of gross mismanagement and substandard care. Many of the problems of understaffing and poor management identified by these enquiries had their origins not in the recent past, but in the Victorian era; they were problems which had consistently been ignored by the general public, by the asylum system, and latterly by the National Health Service and General Nursing Council (Martin, 1984).

The position of the mental nurse in relation to medical staff, to patients, and to the nursing profession itself was identified by the enquiries as ambiguous, this ambiguity having led to lack of direction and initiative in nursing care (Caine & Smail, 1968). The training of mental nurses was found to be totally unsuitable to prepare them to meet the demands of working with patients; it offered as role models only institutionalised senior nurses who had neither the capacity nor the willingness to improve the system within which they operated. Nolan's (1993) interviews with nurses who worked in mental hospitals during the 1960s reveal how senior nurses who had little power within the institution as a whole compensated for their lack of influence by despotic management of the wards and of the lives of patients. They were patronising towards the new health professionals – occupational therapists, physiotherapists and psychologists – and resistant to any attempts to make nurses something more than the mere custodians of understimulated, bored patients: 'The two most common treatments were medication and ECT. . . . The 'good patients' helped on the wards and behaved themselves; the rest either idled their days away on the wards or went to occupational therapy.'

The enquiries found that a training curriculum which was delivered mainly by doctors or by nurse tutors with experience only in general hospitals inevitably undermined the efforts of mental nursing to acquire its own unique identity. The subjects taught to student mental nurses were those of the general nursing syllabus – anatomy, physiology, hygiene, and psychology – but no time was given to the practical aspects of caring for people with mental illness. Nor did tutors follow their students into the clinical areas in order to demonstrate and support good nursing practice. The inevitable result of all this, concluded the enquiries, was that the culture of the mental hospitals was stagnating, to the detriment of both staff and patients.

During the 1970s, as psychiatric nurses began to move out of the hospitals and into the community, they found themselves further challenged to identify what was their particular contribution to the care of mental patients. The works of Altschul (1972), Marks (1973), Cormack (1975), Towel (1975), and Barker (1976) examined the role of the mental nurse and the process of socialisation into nursing. These were skilled researchers, able to employ

sophisticated methodologies to move forward the pioneering work of Maddox (1957) and John (1961) and to encourage other nurses by the quality and relevance of their writing to undertake their own research. The 1980s saw a flood of nurse-led studies focusing on many aspects of nursing care and on the needs of various client groups, including those of patients being cared for in the community (Shanley, 1981; Hall, 1980; MacIlwaine, 1981; Barker, 1982; Butterworth & Skidmore, 1981; Gourney, 1982; Brooking, 1986).

Training for nurses who would be employed in community care was still in its infancy and it was not until 1982 that the General Nursing Council attempted to respond to the growth in community-based nursing by designing an appropriate Syllabus of Training. This Syllabus was based on the premise that the ethos and skills of psychiatric nursing were unique and as such, represented a major step forward for the profession of mental health nursing. This triumph was, however, sadly short-lived because four years later, after the demise of the GNC, the newly formed United Kingdom Central Council for Nursing introduced Project 2000 with the specific aim of amalgamating psychiatric and general nursing. By the end of the 1980s, mental health nursing had become a mere branch programme of a generic training scheme for nurses which was heavily biased towards general nursing (White & Riley, 1993). Project 2000 inevitably fuelled continuing uncertainty about the status of mental health nurses and the value of their contribution to patient care and this, coupled with the urgent needs of increasingly large numbers of patients being discharged into the community, led to yet another government review of mental health nursing in 1994.

The Report of the review, entitled 'Working in Partnership', noted that mental health nurses had still not achieved educational parity with other branches of the nursing profession; they had limited access to academic supervision and few opportunities to acquire research skills. It urged nurses to become specialists in various aspects of community care, in line with government's declared intention of locating mental health services predominantly in the community. Yet by 1993, only 6,000 out of 39,000 mental health nurses in England were employed in the community (Department of Health, 1993). This imbalance reflected an identical imbalance in funding, with 80% of all monies allocated to mental health care going into hospitals and only 20% into community care.

An ongoing debate

In an increasingly competitive health care economy and still without a firm professional base, mental health nursing may be in danger of finding the services it has traditionally offered taken over by other health care workers, by Social Services, or by new non-nursing agencies. The remit of Community Psychiatric Nurses (CPNs) remains as uncertain today as was the role of the attendant in the Victorian asylum, perpetuating a long history of insecurity and ambiguity within the mental nursing profession. There are some who consider that CPNs are essentially primary health care professionals who should be working with GPs, focusing specifically on mental health promotion and acute neurotic conditions, while others would prefer to see them attached to Mental Health Centres providing support to those with long-term mental health problems and their families. The inevitable result of such confusion is that CPNs are not reaching

those most in need of their help (Gournay, 1994). White (1991) reported that 80% of people with schizophrenia were not on the books of CPNs, while Brooker (1994) has identified the need for better training for CPNs to enhance their therapeutic skills and thereby increase their effectiveness in delivering care to clients with schizophrenia.

Various studies have sought to examine what services CPNs are providing and how they are approaching clients. Sladden (1979) concluded that CPNs were most effective when they were 'containing situations' and preventing clients from becoming a burden on other medical and social services; they were less effective at taking preemptive action or measures which might promote lasting change. In a study comparing the work of CPNs with that of social workers, Wooff and Goldberg (1988) concluded that the two groups approached the same clients in very different ways. Where CPNs tended to construct their role in terms of identifying treatment regimes and ensuring that patients took their medication, social workers were more interested in how clients managed their lives and social interactions. The study showed that CPNs spent less time with psychotic than with neurotic clients, and had more contact with the primary health care team than with the mental health team. When engaging with non-schizophrenic clients, CPNs tended to recommend physical and behavioural treatments and were more likely than social workers to be judgmental and directive.

It is cause for concern that CPNs, whose original *raison d'être* was to care for severely mentally ill clients in the community, are apparently not fulfilling this role but directing their energies towards clients with short-term, neurotic conditions whose needs their skills may not be best adapted to meet. In the last two decades, CPNs appear to have been diverted away from the clients who, after discharge from their erstwhile homes within the psychiatric institutions, are now most in need of their skills and support. The 1994 government review of mental health nursing recognised that CPNs had lost sight of their original mission and urged them to refocus their activities on the long-term mentally ill.

CPNs are still eager to stake their claim to a legitimate part in the care of mentally ill clients. Davis (1990) reports on the research activity undertaken by mental health nurses, mostly CPNs, over the last two decades, and concludes that its quantity and quality are major indicators of professional development. Nurses' understanding of the need to provide 'evidence-based care' may bode well for the future, but the need to create a new culture of mental health care as the received wisdom of the institutions become obsolete is urgent. Just as when the asylum system was established, in the middle of the 19th century, there was no clear agenda of care for the guidance of nurses, so community care has been inaugurated before the needs of discharged patients have been identified.

The history of mental health nursing has been marred by remorseless and wilful undervaluing of the men and women who have cared for the mentally sick through the decades, by ad hoc training schemes, by power struggles between the medical and general nursing professions and latterly, by the unconsidered despatch of nurses from the psychiatric hospitals into the community where their traditional skills have proved as archaic as the institutions within which they were fostered. Mental health nursing is still to find its feet in the new world of health care and sadly, the words of the 1956 Expert Committee on psychiatric Nursing remain as true today as they were 40 years ago: 'Psychiatric nursing has developed in an uneven, erratic manner, leaving many gaps in the

care of the mentally ill and in programmes of mental health, even in the most highly organised countries. These gaps present many of the central problems in the field today.'

The repeated failure of mental health nurses to define their role clearly and persuasively has now brought them to a crossroads where there can be no room at all for indecision. If they fail to convince purchasers that they can provide an efficient and cost-effective means of caring for the most vulnerable people in our society, then mental health nursing may find itself disappearing along with the last of the institutions.

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11 Work and Occupation for the Mentally Ill

DOUGLAS BENNETT

Man occupies himself in many ways; but usually work is interspersed with leisure. Work may take the form of economic activity, which can be divided into entrepreneurial or contractual employment. Entrepreneurial work includes shareholding as well as that of the self-employed who decide on the kinds of economic enterprise that will be profitable for them. Employed work requires the worker to carry out the tasks designated by the enterprise for which he has a contract, whereas non-economic work includes the kind where services are not offered for sale, and this is for the family, for charity or for recreation (Jaques, 1960). There is a further distinction between work and occupational therapy; in work, one is generally doing something for other people, whereas in occupational therapy one is doing something for oneself. In work, the outcome is being judged by another person, while in occupational therapy one has to satisfy oneself alone (Bennett, 1972).

This subdivision reflects the different ways in which the mentally ill have been occupied, for there are limitations on the tasks they could perform in a mental hospital and on the ways in which this situation differs from that obtaining in the outside world. Most commonly occupation in employed work and in recreation are the only possible solutions.

Galen is reputed to have said that employment is 'nature's best physician and is essential to human happiness.' Whether or not he said this, psychiatrists like Pinel, Tuke, and Esquirol were all advocating the use of work in the care of the psychiatrically disabled at the end of the eighteenth century. Pinel thought that 'nothing was more striking than the peace and calm which reigned among the mental patients of the Bicêtre during the period that the merchants of Paris furnished manual work to the majority of its patients' (Pinel, 1806).

At the Retreat in York, Samuel Tuke, who probably knew little of Pinel's experiences, was more interested in 'moral treatment'. He said less about occupation, although he notes that female patients are employed 'as much as possible' in sewing, knitting, or domestic affairs, while some assist the attendants. Tuke saw work as a means of ensuring that the patients restrain themselves, and of all the means by which this might be achieved, 'regular employment is perhaps the most generally efficacious.' He preferred, both on a moral and physical account, those forms of employment which are accompanied by considerable bodily action (Tuke, 1816).

Esquirol (1838) too thought that work not only distracted patients' attention from their illness, but fixed their attention on reasonable things. These attitudes informed the era of Moral Treatment, during which the ideals of John Conolly and others favoured the abolition of mechanical restraint. Conolly himself (1847) said 'that among the means of relieving patients from the monotony of an asylum, and preserving bodily health, and, at the same time, of improving the conditions of the mind, and prompting recovery, employment of some kind or other ranks the highest.'

During the rest of the nineteenth century, while the asylums were enlarged and conditions deteriorated, little effort was made to occupy patients. The Mental After Care Association was founded in 1879 and struggled to help 'poor friendless convalescent females' back to normal life and to find employment, but there are few other accounts of positive action. However, most patients, because of symptoms and restraints, were not available for much work and what they did do was considered necessary to the economy of the institution, rather than to their recovery.

Even so, Edward Jarvis (1862), an American who visited asylums in the British Isles in 1860, was impressed by the emptiness of the wards in the daytime – empty and quiet because all the patients were busy at work in the gardens, on the grounds, or in the shops. 'I found these in all the public asylums I visited, for it is the acknowledged policy of those who manage the asylums, to employ the patient's body and brain as much as possible for some real purpose.' Dr Cleaton of Liverpool felt that the abolition of mechanical restraint and 'the extent to which occupation is adopted' were the most recent improvements in the treatment of the insane. He also believed that women should share with men the advantages of outdoor work. 'Some of them are kept too stringently to the monotonous and not very wholesome labour, that of the wash-tub for example.' In their *Manual of Psychological Medicine* (1968) Bucknill and Daniel Hack Tuke said that 'Work, no doubt, has also a moral influence, and in that regard we may call it Occupation, and consider it together with Recreation.'

Reform continued slowly alongside neglect, and sometimes both were intimately related. In 1914, Eva Charlotte Reid, an American doctor, said that 'work might be made a great detriment or a valuable therapeutic agent in the treatment of mental disorders'. She recognised that in many institutions the mentally ill accomplished much of the hard labour, but that there was a tendency 'to make drudges out of the willing and efficient, while those who require to be instructed, supervised or handled with tact were allowed to remain in complete idleness' (Reid, 1914).

The First World and After

In 1919, Dr.D.K. (later Sir David) Henderson introduced occupational therapy at Gartnavel Royal Mental Hospital in Glasgow. Subsequently, he read a paper to the RMPA in 1924 and in the audience was Dr. Elizabeth Casson of Bristol, who in 1924/25 visited the USA, where she saw occupational therapy in practice in Bloomingdale Hospital, New York. Recognising its value, she introduced it into her own nursing home, Dorset House in Clifton, Bristol. It was there that the first school of Occupational Therapy was founded in 1930 (Story of Dorset

House, 1987). The training of occupational therapists had begun in the United States in 1911, but in England, the Board of Control issued a Memorandum on Occupation Therapy (as it was known at this time) for Mental Patients only in 1933. This suggested that it should be prescribed by medical officers, who should visit other mental hospitals to familiarise themselves with the measures available. It was intended to prevent the stage in mental hospitals 'at which idleness, mental and physical, may lead to commencing deterioration of outlook and habit.' The training of nurses, which was seen as vital to its success, was to be planned by the medical superintendent and to be thorough and prolonged. There is no specific mention of occupational therapists, and the exercise was seen as 'a complete change of outlook towards the nursing of the mentally disabled' (Memorandum, 1933).

The activities were not specified, but occupation therapy (*vide supra*) concentrated on diversionary and recreational activities such as rug-making, needlework, leatherwork, art, and music, valuing the creativity of the activity and paying less attention to the demands of those for whom the activity was performed.

In these years after the first world war, Frederick Milner founded the Ex-Services Welfare Society to assist shell-shocked and neurasthenic ex-servicemen. After a hesitant beginning, the Society flourished and provided convalescent accommodation at Leatherhead. In 1927, Mr Everett Howard and the Society's committee recognised the need for the employment of the residents, and a factory manufacturing electric blankets was established, trading under the name of 'Thermega'. This early development in industrial rehabilitation and resettlement attracted little attention, although its value was recognised by Professor Mapother, the society's consultant psychiatrist, when he visited in 1929. He wrote that 'it should be the end to which treatment proper leads for all that large group who are intermediate between fitness for normal employment and fitness for none. . . . It points a moral for application in ordinary psychiatry that may well have wide influence in the future' (Tennent, 1960).

At this time, some attempts were also being made to reform the old asylums, which were still obsessed with ideas of maintaining security; windows were still barred and doors locked. The Maudsley was the first public psychiatric hospital (not an asylum) to be built in the United Kingdom.

It was widely believed that some people were still wrongly detained in the asylums, and Montagu Lomax's revelations influenced Percy Barter, a civil servant in the newly established Ministry of Health (Harding, 1990). Barter advised the setting up of a Royal Commission on Lunacy & Mental Disorder, which sat from 1924-26. It recommended the use of voluntary admission wherever possible and emphasised psychiatry's relationship to general medicine, as well as the need for aftercare of the discharged patient. These recommendations received legislative sanction in the Mental Treatment Act of 1930. The changed view is illustrated in a government report which suggested that the institution should 'no longer be a stagnant pool but should become a flowing lake, always taking in, always sending out' (Report, 1929). In Britain, significant medical advances were taking place in these years in the rehabilitation of people suffering from fractures and tuberculosis, but the Royal Commission report of 1926 laid the foundations of psychiatric rehabilitation. It made possible the voluntary admission of patients to mental hospitals and more importantly their voluntary discharge, although significant changes in practice had to await the ending of

the Second World War. It has been suggested that in the 1930s the organisation of occupational programmes was a topic of importance in psychiatry, but that it then suffered relative neglect as ECT, insulin coma, and prefrontal leucotomy focused attention on the treatment of early cases (Carstairs *et al.*, 1955).

Simon in Germany saw work as part of an educational process aiming at the person's return to everyday life (Simon, 1927, 1929). He felt that inactivity and frequent exposure to the psychotic behaviour of other patients on the ward was mentally and socially demoralising, and attempted to counter this by offering almost all his patients the opportunity to participate in productive work. Simon was both an authoritarian and a humanitarian man, and he favoured discipline backed with punishment. His work was adopted by Dutch psychiatrists and his ideas, in a modified form, found their way to England, following a visit to Holland of a group of English psychiatrists (Evans, 1929). Some years later, another party of British psychiatrists visited Simon's own hospital at Gütersloh.

The English visitors emphasised another result of his innovations, particularly noting that 'where the employment of patients is thoroughly taken in hand the wards are quiet and free from excess of motor activity and there is a great reduction of dirty and destructive habits' (Evans, 1933). Interest in his work spread through Europe in addition to the Netherlands.

In Austria, Jahoda *et al.* (1933) published their observations on the condition and behaviour of the unemployed population of Marental. They showed that the unemployed lost their sense of time, their social contacts were reduced, and they were unable to participate in the collective purposes of society. They also lacked an acceptable status, which had an adverse effect on their personal identity, and finally they lacked any regular activity. This book, written in German, was not widely read in England, though as Jahoda later showed (1982), similar conditions were experienced in South Wales as well as in most mental hospitals in the United Kingdom.

The Second World and After

The Second World War produced a great need for manpower, and psychiatrists were concerned with the effective management of psychiatric casualties. One solution was the Annexure scheme, proposed by Aubrey Lewis for soldiers who failed to adapt to Army conditions and developed psychological symptoms. He suggested that instead of being discharged as unsuitable for combat duties, they should be employed on a type of military work for which they were more fitted, thus fostering the individual's adaptation by a change of environment (Wittkower & Lebeaux, 1943). Similar efforts were made to improve the adjustment of dull and backward soldiers by transferring them to the Pioneer Corps.

In 1941, in the middle of the war, the Ministry of Labour in conjunction with the ministry of Health started an interim scheme for the training and resettlement of the disabled. A couple of years later, an interdepartmental committee on the rehabilitation and resettlement of disabled persons was established. Known as the Tomlinson Committee, it reported in 1943 on the needs of a range of disabled persons, including those suffering from neurosis and psychosis. Its recommendations, which marked a great change in the fortunes of the psychiatrically disordered, were embodied in the Disabled Persons Act

of 1944, which laid down a comprehensive plan for rehabilitation in Britain. However it was not until the late 1950s that a positive use was made of its provisions in psychiatry, since it took time for a change in attitudes to alter the pattern of care. The post-war years were marked by a spirit of optimism, goodwill, and hope, most obviously embodied in the innovative proposals for the National Health Service and the wider evolution of the Welfare State.

The inferior status of mental hospital patients, the conditions under which they were treated, and the inadequate economic resources and staffing devoted to their care, relative to those enjoyed by physically ill patients were recognised and examined by the Royal Commission on the Law relating to Mental Illness & Mental Deficiency which sat from 1954-57 and whose recommendations were given legislative approval in the Mental Health Act of 1959.

More immediately after the War, other changes were taking place outside the mental hospitals. T.E.Main, who during the war had served in Northfield, a military hospital for mentally ill soldiers, had developed group treatments demanding the participation of patients. On his return to civilian life, he coined the term 'therapeutic community' for the unit he established at the Cassel Hospital. Main felt that in the traditional mental hospital, health and stability were often bought at the excessive price of desocialisation (Main, 1946). He recommended a psychotherapeutic rehabilitation approach involving both staff and patients. Even today, both patients and staff clean the Cassel Hospital together, while patients do the cooking.

Maxwell Jones developed similar ideas through his wartime experience treating returned POWs, and he also started a therapeutic community at Belmont Hospital. It is often forgotten that this too was a pioneering rehabilitation unit. It was financed by the Ministry of Labour and was called an 'Industrial Neurosis Unit'. It had workshops and two Disablement Resettlement Officers (DROs) on the permanent staff (Jones, 1956). Its staff believed that 'as now usually practised, occupational therapy cannot claim the rehabilitative effect of productive group work, which is capable of leading to better contact with reality, to behaviour more in accordance with social standards, and to the foundations of self-esteem.' The staff at Belmont Hospital favoured group tasks using production work of real value to the residents (Jones *et al.* 1956).

During the post-war years, occupation for the mentally ill followed the two separate courses of occupational therapy and industrial work. The short-stay neurotic patient tended to be the occupational therapy client, while the longer-stay mental hospital patient was more likely to be engaged in an industrial workshop, although many occupational therapists were also using sub-contracted industrial tasks. As the importance of occupational therapy grew, dissatisfaction was expressed with the training of therapists, which was still largely orientated to the care of the physically disabled (Bennett, 1966). Following a more sober assessment of the outcome of such physical treatments as leucotomy and insulin coma, and with the advent of chlorpromazine and reserpine, there was renewed hope that many more chronic patients in the mental hospitals could be rehabilitated.

Audrey Lewis had laid the foundations for what was to become the MRC Social Psychiatry unit at the Institute of Psychiatry. This was first known as the Unit for Research in Occupational Adaptation, and two members of the staff visited Belgium, Holland, and France to see what these countries were

doing for the occupational treatment of chronic psychotic patients (Carstairs *et al.* 1955). Their interest was doubtless stirred by the findings of two other members of the unit's staff, who had been studying the use of work in the training of the mentally retarded. Tizard & O'Connor (1952) were dissatisfied with the established methods of training for the mentally retarded which, they felt, used equipment which was out of date and uneconomic. They also felt that these methods did not prepare the retarded for employment outside the institution. They therefore persuaded firms outside the hospital to provide simple sub-contracted work which the patients could carry out and for which they were paid. Carstairs & O'Connor subsequently established industrial workshops embodying these principles for psychotic patients at Banstead Hospital, where research was undertaken (Carstairs *et al.*, 1956).

At this time, Lewis proposed that occupation had a two-fold importance.

Within the hospital it provides the patient with satisfaction and brings him into close and co-operative contact with other people in relationships that are familiar to him: if his work is paid for, in the way he was accustomed to in his pre-hospital life, he is thereby helped to retain social habits centring on the use of money, and to make decisions which are not called for in a conventional old-fashioned mental hospital setting but which are part and parcel of everyday life in the community. Outside the hospital his independence and self-respect will depend in large part on his ability to earn his living: it is unnecessary to dilate on the manifold importance of work in our modern society, indeed in almost all societies. (Lewis, 1957)

Lewis made no distinction between work and occupation, but equated them.

1960-1980 The Years of Growth

The combination of the Welfare State, the opportunities offered by full employment, Maxewell Jones' example, and the Social Psychiatry Research Unit's work, together stimulated the interest of medical staff in the traditional mental hospitals to the possible advantages of work for patients. In 1959, Charlton reported that 58 hospitals were carrying out industrial therapy. The impulse to provide work spread rapidly and a sophisticated industrial factory was developed at Cheadle Royal, a private hospital outside the NHS (Wadsworth *et al.*, 1958).

However, that hospital's system of making and marketing its own products was not copied as widely as the model developed by Donal Early, an innovative psychiatrist, working in a hospital mainly for chronic patients in Bristol. In 1957, he introduced industrial work for 14 patients in Fishponds (later renamed Glenside) Hospital; the number involved expanded rapidly to 385 in the following year. Impressed by the success of the scheme, Early felt that further training in the community would be required if these former long-stay patients were to find a place in open industry. Industrialists too were impressed with the quality of the work achieved and together with some civic dignitaries, representatives of the Church, and of the trade unions, joined with Early in establishing the Bristol Industrial Therapy Organisation (ITO). This was a non-profit company, omitted

by guarantee, which offered medically and industrially supervised training for the employment of disabled psychiatric patients, often outside the hospital and under conditions approximating to those found in an ordinary factory (Early, 1963). This model has been replicated in Ealing, Reading, in Ireland, and elsewhere. A different pattern of service, where a central psychiatric hospital was solely engaged in providing a rehabilitation service for disabled patients for mental hospitals in the Birmingham area, was established at St. Wulstans in Malvern by Roger Morgan (Morgan *et al.*, 1965). However, no other facility of this type was created anywhere else in Britain.

Ideas of rehabilitation, often expressed in terms of resettlement, were gaining wider acceptance, but for this to be achieved, patients 'should be employed at productive, useful and satisfying work for which they should receive proper economic rewards' (Kidd, 1965). Kidd sent a questionnaire to 151 hospitals; of the 90 which replied, 78 possessed an industrial unit, the majority having between 20% and 30% of their patients occupied in this way. At this time, psychiatrists were beginning to consider the relative appropriateness of the type of occupation for patients with varying types and degrees of illness and disability. There was growing concern about the unoccupied state of a large number of mental hospital patients, but it was not easy to provide work for a hospital population which might number over 1,500 people. In the large hospitals, many patients went to occupational therapy department, and many were employed in the hospital utility departments and gardens, while hospital workshops provided work which required less intensive supervision for many others. Most hospitals favoured this approach, although research had not yet compared the benefits of occupational therapy against those of industrial therapy.

Later Wansbrough & Miles (1968) reported a similar survey of 122 hospitals 100 of which said they had an industrial unit, although only 74 could answer the questionnaire. They found that 13,173 patients (26%) were engaged in industrial therapy, 25% were doing domestic duties, 31% attended occupational therapy, and 14% were occupied in the hospital utility department, e.g. laundry, sewing room, etc. However it seems from this author's experience of mental hospitals at that time that the respondents must have seriously underestimated the number of resident unemployed patients.

Questions were also being asked then about the staffing of these occupational units, and Wansbrough & Miles sought information about the professional training and allegiance of the staff involved in various types of occupation for patients. They found that the large majority (65%) were nursing staff, the total occupational therapy staff represented 18%, while industrially qualified staff were only 7.5%. There were problems with the pay of the industrial supervisors, who could only command a salary much less than that earned by a comparably qualified person in outside industry.

At this time, Bennett (1972) noted that the supervisors who had come from industry had quite a different outlook from that of the nurses and other clinical staff. The medical view of the patient's difficulties tends to emphasise what is wrong and why he/she is unable to cope as others do, whereas the industrial supervisors are more anxious to find out what the patient can do. If the patient has difficulty, they do not see it in terms of illness or excuse it, but instead look at how the patient's coping can be improved.

There were various methods of calculating the patient's pay, but whichever was

employed, in the late 1960s the patient could usually only earn a maximum of £2 weekly. Under these circumstances, it is not surprising that questions were also raised about the relative value of productive paid industrial work on the one hand and occupational therapy, with its emphasis on patient's creative activities, on the other. Macdonald (1960), a pioneer of occupational therapy, was generally critical of industrial work, saying that when work is accepted on contract form outside the mental hospital, 'there is a tendency to "press gang" unsuitable patients, or patients who might benefit from part-time but not full-time work on to the "production belt"'.

Bickford (1954) had been equally critical of occupational therapy as letting patients just do something they had a gift for doing, e.g. making rugs and knitting even 'if the heavens were falling and the world crashing down around them'. In his view, there was 'nothing therapeutic in the overwhelming majority of occupational classes up and down the country.' However, Hutt *et al.* (1964) said that while the value of occupation had been demonstrated, 'there are few studies comparing the relative efficacy of different types of occupation in the social adjustment of patients.' Therefore, they went on to compare three groups of occupations. The first was employment in the hospital utility departments, e.g. the laundry or bakery; such work was seen as routine, providing cheap labour for the maintenance of the hospital. The second group were those patients engaged in occupational therapy, which was seen as 'arts and crafts'. The third group were occupied in industrial work, as favoured by Carstairs (1958), but as noted above, subjected to Miss Macdonald's criticism. The subjects of the study were transferred between the three situations over a period of only 38 weeks, but the nature of the adaptation, which was assessed outside the working situation, showed 'virtually no differences between the various working groups.' There were some differences due to change of job, but these were not truly significant.

A similar study of the reaction of two groups of long-stay schizophrenic patients in an industrial unit and an occupational therapy unit was made some years later by Miles (1971). She saw industrial units as producing marketable goods, while occupational therapy units were offering diversionary activities, such as arts and crafts, the product of which may or may not be sold, when finished. She compared 26 patients in each group, first in terms of their willingness to work, and secondly their ability to work, as measured at the beginning of the study and again six months later. The results showed that the industrial unit was more successful than the occupational therapy unit in improving the patients' ability and willingness to work. The younger short-stay patients showed most improvement in both units, while female middle-class patients showed the greatest gains in the occupational therapy unit. She also compared patients randomly allocated to either a workshop engaged in paid industrial subcontract work, with staff who had industrial but no psychiatric experience, or to an occupational therapy department where unpaid patients were occupied in art and crafts and received pocket money. The results showed that the extent, if not the depth, of the patient's personal relationships were greater in the industrial workshop, and led her to speculate that industrial work was a social activity which required contact and co-operation between patients, while in occupational therapy, the patient worked on his/her own without needing to offer or to receive help (Miles, 1972).

During the 1960s, paid industrial work had tended to find favour in a hospital environment increasingly directed to the rehabilitation and resettlement in employment and discharge of the less disabled patients. Recognising that not all patients were capable of open economic employment, Bennett & Wing (1963) looked at the advantages and difficulties in providing sheltered work for the psychiatrically handicapped.

They pointed out the difficulties of obtaining a regular supply of work, as well as the need for a financial subsidy and for the careful assessment of the patients' performance. The fact that 'no opinion should be expressed that does not depend on a practical trial of the patient's capacity' was stressed.

If the establishment of such workshops was to be more than a passing fashion, a clear understanding of their function for the disabled psychiatric patient's varied needs was essential. These authors saw Hospital workshops, Sheltered workshops, Industrial Rehabilitation Units, Remploy factories, as well as other industrial rehabilitation and resettlement units as essential facilities in a comprehensive and flexible system. Today, the term 'Sheltered Factory' is usually the description of a Remploy-type factory for the permanent employment of the disabled.

The definition of disabilities by Wing (1963) was an important step in the development of a coherent policy of rehabilitation and of the use of work in this process. Wing proposed the separation of disabilities into three types, according to their cause. Primary disabilities are part of the person's illness; thus in schizophrenia, incoherent thought processes, delusional motivation, catatonic slowness, and apathy are of this type. Secondary disabilities are those emotional and social difficulties which are the lot of most handicapped people, and which express the patient's own and other people's reaction to his illness. Tertiary disabilities were those that were present before the onset of the illness, such as low intelligence, poor education, and social deprivation. This classification made it evident which disabilities might be changed by occupation.

Thus, work did little to change the primary disabilities, but employment work, if it were properly paid according to the terms negotiated by Trade Unions in the outside world, did give the disabled a role other than that of patient (Parsons & Fox, 1952). Work was also shown to have a psychological component which required the exercise of mental and perceptuo-motor judgement, and this might explain some of its value in rehabilitation (Jaques, 1960; Bennett, 1970). There were other effects: Jahoda (1982) proposed that outside the nuclear family, it is employment that provides most people with the social context for their individualism. Employment demonstrates that no man is an island, and that the purposes of the collectivity transcend the purposes of the individual. Without this daily demonstration, the unemployed suffer from lack of purpose, exclusion from the larger society, and relative social isolation.

After 1980. Unemployment, Decline of the Mental Hospitals and Innovation in the Community

Times were changing and as it came to be seen that the large mental hospitals would be closed, it was considered that rehabilitation, including that of psychiatric patients would move into the general hospital. Accordingly, the Tunbridge Committee was asked to consider the future of rehabilitation in district general

hospitals. In its report (Report, 1972), this committee declared that work was an essential component of psychiatric rehabilitation. The increasing numbers of elderly and psychogeriatric patients needed to be rehabilitated, but they did not require industrial preparation. For them, it recommended the provision of handicraft rooms (in addition to the workshops), so that separate facilities for medical and for industrial rehabilitation would be provided. It further recognised that patients referred for industrial resettlement needed longer preparation before being transferred to one of the Department of Employment's Industrial Resettlement Units (IRUs), and that this preparation could be provided in the workshops of an Industrial Therapy Organisation. Sheltered workshops were intended for those patients who, after careful preparation and assessment, were deemed to be too disabled for open employment. So some of the psychiatrically disabled would progress from handicrafts to simple industrial work, then on to more demanding industrial work, before being transferred to one of the Ministry of Labour's Industrial Resettlement Units. In practice, however, relatively few psychiatrically disabled people end up in sheltered workshops.

In 1975, Early, reported that Bristol ITO had been placing patients in sheltered groups in open industry for the past 12 years. In that year, the Department of Employment was re-examining its sheltered work policy, and had introduced the concept of the 'enclave'. Early objected to this work (which he saw as meaning 'territory surrounded by foreign domination'), although not to the underlying concept, which was of a group of severely disabled people working together 'under special supervision in an otherwise ordinary and undifferentiated working environment.' The name was later changed, and people then spoke of 'Sheltered Groups in Industry'. The scheme required a sponsor, who was the legal employer and paid the sheltered worker's wages, while the host firm, who provided the work, paid through the sponsor for the work done. During 1963-64, when industry was booming such groups were introduced into four factories.

The scheme had its ups and its downs, but the employees, like those of the ITO proper, were generally middle-aged, single or without a surviving partner, unskilled or unemployed, and many had been long stay mental hospital residents. About a quarter eventually went to open employment at this period (Early, 1975). Nevertheless other observers believed that sheltered groups in industry helped those employed in them further along the road to complete integration in the national workforce than if they were channelled into a traditional workshop (Wansbrough & Cooper, 1984). However, this scheme was replaced by a similarly funded 'Sheltered Placement Scheme', for individuals rather than groups, though it has disappointed the hopes placed in it. In 1990, only 6% of the 6,700 places were filled by the mentally ill, while those with mental handicap occupied 42%.

In the mid-1980s, a conference was held which asked whether rehabilitation had a future or whether it had reached the end of the road (Herbst, 1984). It was perhaps a sign of the times that rehabilitation was then discussed almost entirely in terms of work and occupation. The position of workshops was changing, and there was uncertainty about the future of rehabilitation and the place of work in that process. Dick (1984) spoke of the change from the 1960s to the 1980s, feeling that there had been a loss of impetus in the use of work in psychiatric hospitals, and that many industrial units and work programmes

were 'pale shadows of what they were some years ago.' He recognised that the patients who formerly would have benefitted had moved out of the hospital into more domestic settings. He also noted that some of those former patients now living outside the hospitals were busily and realistically occupied with their daily chores. It was questioned why we should persist in the occupational rehabilitation of patients, when so few were likely to return to open employment. In 1984, unemployment had risen in many localities above 6%, which Morgan & Cheadle (1975) considered to be above the level essential if mentally disabled people were to be resettled. More than 40% of patients who had undergone work rehabilitation were never placed in open employment, even in the best years of full unemployment. There was general agreement however, that in the mental hospital environment, engagement in regular occupation helped to maintain the individual from developing further disabilities. Shepherd (1984) drew attention to the shortage of community-based, work-orientated day places, and noted that day hospitals and centres were offering games and quizzes, sewing and painting, while relatively little emphasis was being placed on work-like activities. Of course, psychiatric patients have always taken part in such occupational therapy activities.

Over the years, occupational therapists' work and training have changed, and most new entrants are now qualifying by university degree. Their training has always been concerned with the occupation of the physically, as well as with the psychiatrically disabled, whether adults or children, and also with the mentally handicapped and drug abusers. In psychiatry occupational therapy's work-base has always featured non-productive occupations such as art, music, drama, social, leisure, and recreational activities. Some occupational therapists are also engaged in work therapy, skills training, and activities of daily living. However, this expansion of activities was halted in the 1970s, when Art Therapy and Music Therapy expanded and became more established. At the level of practice, occupational therapists were negotiating with the Department of Health to establish a separate career and pay structure for themselves in the NHS.

Occupational therapists, however felt that their position was threatened, and sought to continue to manage these creative therapists. They did not succeed, and art and music therapists established their separate careers in the NHS in 1982, although they cannot work in the education service without teacher training. Music therapists are concentrated in the south-east of England and only 15% work with the mentally ill (Wigram *et al.* 1993). Today, occupational therapists are more interested in the assessment and development of people's functional skills: skills which are valuable in overall human adaptation and adjustment but craft, creative, domestic, and leisure skills still vie with the trade and technical skills of occupation (Hagedorn, 1992).

Since the early 1980s, there has been considerable social change, both inside mental hospitals and in society. Over 40 mental hospitals have closed their doors and others are running down their populations, so that only those who are very elderly or have a very long stay remain (Davidge *et al.* 1993). Since hospital admissions are of much shorter duration than in the past, there is less opportunity to undertake any long-term rehabilitation activity.

Staff in both hospitals and the social services have concentrated on the provision of residential accommodation for those patients who have been discharged and can no longer return to their families. There has been an

ageing of the population, and many of the elderly who require residential provision receive it in a nursing home or other sheltered residence, rather than in a hospital. In the world outside, there has not only been an increase in the level of unemployment, but also a change in the pattern of employment, in which more women, and also more men are engaged in temporary or part-time work. Very large companies are disappearing, due to competition in the world market.

At the same time, the bogey of Communism has collapsed, the unions have lost power, and even managers have lost the expectation of lifetime employment. Further, the expectation of, and demand for, greater levels of skill mean that simple employment is not as easily available as it was formerly. In particular, there has been a reduction in labouring work, fewer houses are being built, and there is a shortage of simple clerical work in banks and offices.

Some new initiatives have been proposed in the form of 'social firms'. These are small businesses with a mix of disabled and non-disabled employees, operating in a commercial fashion and paying the employees, (who are not receiving benefits), an industrial wage. Their difficulties are all in the area of finance and Grove (1994) maintains that unless they have the support of a specialist rehabilitation workshop and local business, they are as vulnerable to closure as any small business is in hard economic times.

The run-down of mental hospitals has been countered to some extent by the establishment of work units in the community. It is difficult to obtain a clear picture of what is available although the booklet *'Working Out'* (MIND, 1990) lists 357 projects for mentally ill or emotionally distressed people who have had difficulty and want to get back to work. The projects listed usually accept people from their local authority or health authority area. Some are projects run by the National Association for the Care and Rehabilitation of Offenders (NACRO), while others operate under Employment Training which may limit attendance to 6 or 12 months, and they do not seem to represent many of the schemes *not* directed to eventual vocational placement in open economic employment. Gentry (1995) has also listed some 26 hospital industrial units that have moved out into the community or are moving there in the future.

Employment Centres (ERC) have replaced the Industrial Resettlement Units (IRUs), which earlier research showed to be so useful in helping both moderately and severely disabled psychiatric patients back to work. A positive attitude to work proved to be a more important predictor of success than the severity of psychiatric symptoms (Wing *et al.* 1964). Unfortunately, the ERCs, like other employment services and other policies developed in the 1940s and 1950s, are less effective in the 1980s. In 1946, 70% of the intake were placed in employment, but by 1977, only 25% were so placed (Cornes *et al.*, 1982). These authors challenge the view that the poorer performance of the units is a result of an increasing number of mentally ill clients, saying that their number has remained constant at about 20% for many years.

While the mentally ill did not do worse than any other disability group, it was recognised that they needed adequate preparation and a positive attitude to work before they entered the ERC. Once again, it was said that they needed a longer period of training than the ERC offered – a fact which had been noted earlier (Bennett, 1972, 1975). Nevertheless, the huge increase in the level of unemployment certainly posed a significant threat to vocational rehabilitation

(Midgley, 1990). Any alteration in this situation will require major action by the Government and it will doubtless be some years before we see psychiatrically disabled people claiming not just the right to work, but the right to employment, in the way that the more militant physically disabled demonstrate for the right to physical access.

In these changed economic circumstances, many psychiatrists no longer see the need for patients' occupation in work, when the opportunities for open paid employment for the disabled have been greatly diminished. Yet in spite of profound social changes, the prevalence of psychiatric disabilities has not altered, and work, however it is organised, wherever it takes place, and however much it has to be supplemented by other activities, remains an 'essential if not a sufficient part of the now expanded array of rehabilitative activities' (Bennett, 1984). Nevertheless, a local authority planner was heard to say that there was no justification for sheltered workshops; it was more economical to pay the people to stay at home and do nothing. This is unfortunate, for work is still important for the psychiatrically disabled, even if employment is unavailable. Lack of work deprives a person of social structure in which he/she has to go somewhere to do something with somebody at a certain time, which is such a 'culturally normative' part of everyday life, that we rarely consider it. No other activity for psychiatrically disabled people can compare with work – not only for their rehabilitation or resettlement, but for the relief of symptoms as well as the enhancement of their functioning and general benefit (Rowland & Perkins, 1988). This is even more important, now that widely available community services will be required to serve an increasingly disabled psychiatric population.

A more recent innovation is to take the user's views into account, as reported by Rowland & Perkins, who examined the views of 37 patients in a rehabilitation unit. Work was marked as the most important activity, followed in order by: being with other people, medication, and meals. Talking to the staff was rated as least important. They also reported a study of attenders at another unit, who were asked why work was important to them. They rated in order: making money, which came above the work itself, followed by somewhere to go, and shortly after that, a place to meet friends.

Some observers, while recognising the value of work, warn that the disenchantment with opportunities for employed work might lead to a return to therapy and a more enthusiastic preparation for a leisure culture (Pilling, 1988; Bridges *et al.* 1994). Although Busuttil (1992) says that 'there is confusion and disagreement over what occupational therapy is and does', he still links industrial therapy, art therapy, drama therapy, music therapy and play therapy together. Kelve, (1980) does not believe that it is sufficient to look to leisure activities in terms of what they may have to offer to psychiatrically disabled patients. It is essential to look at them in terms of what they would have to do, if they were to replace the psychological functions of work. So we may agree with Rowland and Perkins that work is a very versatile tool to meet the needs of a heterogeneous group of individuals and that there are perhaps too few initiatives catering for the non-vocational needs of the more severely disabled psychiatric patients. Work is without doubt a potent tool of great utility and even though, over the years, its importance waxes and wanes, it will remain essential as a social and psychological human function for the psychiatrically disabled, as it is for all of us.

At present, occupation of psychiatric patients seem to be lacking in direction,

but in the future, as it becomes clear that the provision of residential care and the chores of daily living are not a sufficient remedy for those individuals with long-standing psychiatric disabilities, psychiatrists will once again have to consider the place of occupation in their services.

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12 Training and Education in British Psychiatry 1770 – 1970

JOHN L. CRAMMER

Training is learning to perform actions, education develops understanding. The first gives recipes to produce specific results, and improves performance by practice. The second draws together knowledge from various related fields, organises it with concepts and hypotheses, and applies it imaginatively in the solution of practical problems.

Use of the words ‘psychiatry’ and ‘psychiatrist’ in common English really date from the 1930s (though first imported as early as 1846, but very rarely used). This is a warning that the medical specialism so named, and the special doctors who practise it, are new, and that the kinds of illness accepted for treatment and the kinds of treatment given have changed very considerably since about 1900. To call the eighteenth century ‘mad-doctor’ or the nineteenth century asylum doctor a ‘psychiatrist’ is to misunderstand what that person was required to do and was capable of doing at those periods. For many centuries human *conscious* life and spirituality were taken for granted: psychological science, dissecting the mind/brain into mechanisms and analysing human-human interactions, is little more than a century old.

The period 1770 to 1971 has seen many changes in medical concepts and in the boundaries of medical knowledge, as well as many social changes, all modifying the handing on of medical practice. Training and education can only be understood in that light. The population of England and Wales which had for centuries not been more than five million started to grow from about 1750, reaching 32 million by 1901, and this expansion was primarily in the towns and cities and away from scattered rural villages. Urbanisation (and ease of travel) created public health problems, some in the field of abnormal behaviour. For instance, big urban houses had big resident domestic staff from the country: those who fell ill could not be sent home and might require institutional care. Changes in numbers and concentrations of people have forced historical development in medical care.

But in addition to urban population growth came wealth, thanks partly to the extension of empire, especially in India. Wealth can create new disease, awareness of disease, and the employment of many more doctors (Holloway, 1964). Now began the era of the private madhouse, to relieve families. They were usually run for profit by a layperson, who undertook the resident care of a few patients, usually anything from 5 to 50, in some converted house or stables.

The resultant abuses occupied Parliament over a considerable time. Inconvenient heiresses and business partners were sometimes wrongfully imprisoned, some patients were ill-fed, dirty, and brutally treated, and those who fell ill physically might be neglected and die. Complaints, partly by those who paid the bills, went on in spite of successive regulations: that 'mad' houses had to be licensed and specific records kept, magistrates be involved in admission procedures, and premises regularly inspected. Poor patients who wandered might end up in a gaol or workhouse, where their presence was often disruptive. But some of them were sent to the private licensed houses, at special cheap rates, paid for by their own parishes.

The Public Asylum and its Doctor

The Parliamentary Act of 1808 'for the better care and maintenance of lunatics, being paupers or criminals in England' invented the public asylum. Magistrates in each county were authorised to construct and maintain a specially designed building to house the lunatics of the county, free of charge to the patients and their families. This was on a non-profit basis, the magistrates having no financial interest in it and meeting the costs by collecting a county tax or rate. As in the licensed houses, the weekly costs of the poor patients were to be paid by their parishes, but paying patients could also be admitted, particularly if the magistrates collaborated with some local charity to that end. There was no mention of any doctor to be on the staff.

This was pure local government, which was then by Justices of the Peace meeting in Quarter Sessions. Central government had virtually no role.

Amending Acts were passed in 1815, 1819, 1824, and then in 1828 one which said that every institution with 100 or more inpatients must have a full-time resident medical officer, who would visit all the patients every day (smaller places could have a non-resident doctor with a contract to visit a fixed number of times per week, pro rata for the number of patients). This was the response to continuing high physical morbidity and mortality among asylum inmates¹: it appeared that through ignorance, callousness, or unwillingness to pay fees the asylum attendants were not summoning outside doctors when needed.

One of the first discoveries from asylum practice was that many newly-admitted patients already had physical illness of some kind in addition, and that the conditions in the asylums and licensed houses were such as to promote skin, gastrointestinal, and chest diseases. Mad people more often got into fights, broke a limb or cut themselves, and they tended to neglect bodily cleanliness and keeping warm.

The asylum doctor found himself not only treating physical ills but teaching the attendants how to nurse, helping the epileptic to breathe, the paralytic to eat without inhaling food or vomit, and the bedridden to turn. In the interests of preventive medicine he tried to see to the hospital diet, the fresh air and exercise, the avoidance of cold draughts, and the overcrowding that patients increasingly experienced. For what began as an asylum for 50-100 inmates often turned into one of nearly 3000. What started as a place of humane care to protect the sufferer became in a century a place of storage to protect society.²

Eventually, the doctor also became the chief administrator (superintendent)

of the asylum under the magistrates who employed him, but placed over the steward, attendants and nurses, and domestic and outside staff. As the asylum grew, the superintendent was able to take on an extra assistant – a junior doctor – for every 300-400 more patients. Many such doctors, after a year or two, moved on to private practice or to specialise in obstetrics or surgery, or went overseas.

Until about 1870, superintendents often described themselves as ‘surgeon’ in the *Medical Directory*; this was short for surgeon-apothecary (LSA, MRCS, a general-trained doctor). They received (and required) no training beyond what every medical student got. They had no say in who was to be admitted to their asylum: in general, they did no clinical work outside its bounds, and their practical experience of mental illness was limited to what they saw in their own asylums. From about 1865, they began to refer to themselves as ‘medico-psychologists’. Their overall purpose was to conduct a humane regime, but this was often frustrated by extreme financial stringency and overcrowding, by the repressive legislation of the 1890 Lunacy Act, and by their own intellectual isolation and self-satisfaction. Some patients recovered, but apart from maintaining physical health and preventing suicide, it was not clear that their treatment had anything special to do with it. From years of experience, the asylum doctors learned administration and something of the ways of the mad. They became specialists: ‘alienists’, a much narrower field than psychological medicine.

In 1800, every doctor was prepared to tackle everything. Conditions labelled ‘hysteria’, or ‘hypochondriasis’, ‘anorexia’, or ‘fits’ were already finding their way into general hospitals (Risse, 1986), and what we would now classify as neurotic conditions were treated at home. Any doctor might be expected to advise on competence to make a will, or the state of mind of a man accused of murder; or to advise a magistrate on the evidence for insanity.

Medical Schools and Medical Theory

In England, the teaching of medicine was always primarily by apprenticeship; it was hardly a university subject till after 1920. A medical school was a local private enterprise, usually started by some enthusiastic doctor who wanted to offer a course of lectures, and joined with a few others of like mind. Students paid a fee to attend each subject course; if they did not register, the course dried up. They could go wherever they liked. Clinical experience, so important in training, was gained by apprenticeship watching and copying an experienced practitioner, and later by following a surgeon or physician in his round of the wards in some general hospital; many provincial general hospitals had been founded in the eighteenth century.

Surgeons often got their initial experience from three years with some army on a campaign. Physicians were educated men who could read Latin and therefore the classical medical texts. This meant a university education, only obtainable in England at Oxford and Cambridge, which had no clinical opportunities, being in very small towns. Some physicians got their degree abroad, at Leiden, Paris, or Padua, or particularly at Edinburgh, where the University was run by the City Council, and accepted all comers. The England of 1783 had for a population of five million, 89 surgeons, 363 physicians, and 2607 surgeon-apothecaries, the last

trained only by apprenticeship (Loudon, 1986, p.26) – just over 3,000 in total. Only the physicians practising in London or for seven miles round were under the control of the Royal College of Physicians (founded 1518), while the Society of Apothecaries (1617) had a very loose control of its members over a much wider area. Most doctors pleased themselves what they learned before setting up in practice wherever they fancied. There were no rules.³

Only from 1815 was it made compulsory by law to pass an examination before being licensed to practice, and if this was not a licence or degree of an established university or college, it had to be the new Licence expressly established by the Society of Apothecaries (LSA). Initially a purely oral exam (but written after 1838), this could only be taken after proof of attending two courses each of lectures on anatomy and physiology and on the theory and practice of medicine, and one course each on chemistry and materia medica (primarily education). In addition a five-year apprenticeship and six months' hospital experience were required (primarily training). Only from 1858 was there an annual *Medical Register*, listing all those licensed to practice, – then about 15,000, a fivefold increase in 75 years. This was published by the new General Medical Council. This body endeavoured to harmonise to a common standard the final examinations of the 19 bodies which then awarded licences in the British Isles, and to press for an up-to-date curriculum of studies (a little psychological medicine should be taught, the Council said in 1885). Students for long remained peripatetic. It was only around 1870 that they began to choose one school and stay with it for the whole of their training, and the schools responded by each supplying teachers in all the required subjects.

The Medical Act of 1950 allowed the Council for the first time to inspect medical schools, and in 1978, postgraduate medical education was included in their remit; very recently, postgraduate vocational qualifications have begun to be included on the Register. We have moved from laissez-faire into an era of State regulation of each stage of professional life: undergraduate, postgraduate, and continuing professional education until retirement.

Early Specialist Teaching: Postgraduate and Undergraduate

The first postgraduate teaching on mental illness began in London with the foundation of its second charity hospital for these disorders (after Bethlem) – St Luke's, in 1751. This was established partly so that 'gentlemen of the Faculty' could gain practical experience (French, 1951). The Governors authorised admission of pupils in 1753, but rescinded it in 1803. Its chief until 1764, Dr William Battie, published his lectures as *Treatise on Madness* in 1758 – a brief work. St Luke's continued intermittently to play a training role – in 1843 free clinical lectures were resumed, and certificates of attendance at its medical practice issued, while in 1875, it began to have two resident clinical assistants (free board and lodging, no pay) at a time. Later, it was judged too small to offer adequate experience.

However, it is important to appreciate that those who became asylum doctors (from 1828 on) were not required to have had any specialist training, nor any knowledge beyond what every licensed doctor might know (and he had no formal systematic training in the diagnosis and treatment of mental disorder,

or in hospital administration). The asylum doctor learned on the job, or from his senior if any, and he could read books and journals. His employment was conceived of as that of a generalist, he was not there to find new cures, or do research, or teach, but to organise physical care.

The lecturers in mental pathology appointed at medical schools from *circa* 1870 gave annual summer courses of lectures and sometimes organised some demonstration of patients. This does not mean that before 1870 there was no teaching of what we now call psychological medicine. But since clinical phenomena were comprehended differently in the past, the concepts were lacking, and the practical purposes were different. Therefore, we have to search to identify the teaching, because it came in other guises, partly in general medicine, partly elsewhere.

As early as 1840, London medical schools offered courses in forensic medicine, and some lecturers published their teaching in textbooks. Thus, from Kings College Hospital in 1844 came W. A. Guy's *Principles of Forensic Medicine*, 500 pages long with 70 on Insanity. This tells the student how to take a history, how to examine the patient's facial expression, posture, and gait, use simple tests of orientation, memory, and arithmetic, and make diagnoses such as drunkenness, dreaming, somnambulism, amentia, dementia, mania, and moral insanity. At the same time from Guy's Hospital came A. Swaine Taylor's *Manual of Medical Jurisprudence* – similar in size and contents, which went through many editions. Practical use, here forensic, determined what was taught, no matter under what heading.

A striking example of this is the early nineteenth century enthusiasm for what came to be called 'Phrenology' (Cooter, 1981). On the basis of his scientific work, the Austrian neuro-anatomist Gall (1758-1828) put forward the following propositions: The brain is always the seat of mental disorder; it has a complex anatomy, varying in detail from individual to individual; different brain areas are responsible for different psychological functions (aggression, erotic behaviour, memory, mathematical ability, etc.) and the balance between them makes the personality; the same areas in different individuals differ in size; in mental illness there has been an excessive shrinkage or expansion of one or more areas; the size of an area influences the shape of the skull over it, which can be felt on examination – so that feeling the bumps allows for an analysis of personality and explains individual mental disturbance.

These ideas were received with enthusiasm in Britain, leading to the formation of phrenological societies to discuss them and practise skull palpation. There were courses of lectures at some medical schools (the London, St Thomas's, Manchester, Glasgow, Edinburgh), as well as the publication of regular journals. They offered a clear plausible theory of the brain and the mind, based on scientific evidence, and proposing practical use in the diagnosis of mental illness and disabilities, with extensions in criminology, anthropology, and education.

The scientific evidence was that the brain is anatomically complex, differs in size and detail from individual to individual, and the localisation of some functions was indeed appearing. But as Pinel was already writing in 1806 (Section 3 of English translation), the skull gets its final form soon after birth and there is no evidence that changes in the brain inside can modify its external form. He advocated the introduction of standard skull measurements to be applied to groups of young and old, normal and specifically abnormal,

with statistical analysis of the results to test Gall's proposal. But he was far ahead of his time. Clinicians were innocent about statistics and group study. They individually examined their patients and convinced themselves they could read the personality within. It was only slowly that enthusiasms and belief died, doubt crept in when it was realised that phrenology provided no useful guide to treatment. By 1850, the excitement was over: feeling the skull was misguided and useless.

But Gall had offered a theory of brain function where there was none before, and his ideas encouraged a great burst of activity in neuropathology. In France this led to knowledge of the cause of general paresis (an illness which contributed considerably to the numbers of inmates in nineteenth century asylums) and in Germany to the recognition of Alzheimer's and similar brain degenerations, to possible relations between epilepsy and psychosis, and the development of the therapeutic value of ECT. These studies also revealed associations between local brain lesions and neurological symptoms and behaviour. But the psychological functions were wrongly conceptualised in Gall's day: more useful ideas about them date from after 1870.

Phrenology emphasised the examination of the individual, and suggested that the cause of a mental illness lay within that person. This was at the time when Pinel, Tuke, and others were introducing 'Moral Treatment', viewing the lunatic not as an irrational wild animal, but as a human being who retained much of his humanity and could be befriended and emotionally guided. It provided the ground work for the 'no-restraint' movement in asylums in the 1830s and 40s. So phrenology, though a theory and a false 'skill' that spread across medicine and then died, did contribute in the end to psychological medicine.

Another Viennese physician, Mesmer, had discovered the powerful therapeutic effects of suggestion, and of human-human interactions. However, he interpreted his findings not in psychological terms but in analogy to the then fashionable physics of static electricity – 'animal magnetism' – mesmerism, or (later) hypnosis. Not only could all sorts of symptoms, especially pain, be strikingly relieved, but subjects could be made to act in all kinds of strange ways, apparently abrogating their own wills. This last became a matter for theatrical performances, and also of concern to moralists, who feared that hypnotism opened the door to sexual seduction or to murder by automata.

Partly through Mesmer's own paranoid outlook, partly through doctors' suspicion of therapeutic rivalry, practical knowledge of mesmerism spread chiefly through lay societies, and was viewed as quackery by scientists. They dismissed mesmerism as nonsense, once they had experimentally disproved the physical theory ('magnetism') and some (but not all) of the observations on which it was based. The time for precise individual clinical records, and also the analysis of large groups of them, had not yet arrived in medical practice. Since psychological science did not yet exist, the phenomena were not studied for their own sake; there was no idea of seeing them as an aspect of human nature, subject to natural law.

Hypnotism had a strange history (Gould, 1992), on the fringe of medical practice; in England it appears never to have become part of an undergraduate or postgraduate (psychiatric) course. In the mid-nineteenth century in the hands of Braid and Esdaile, it nearly became a method of analgesia in surgery, but was beaten by the arrival of anaesthesia. Later, in France, it was taken up in

Nancy and in Paris, where Charcot brought it into neuro-psychology and Janet and Freud applied it in psychotherapy. It began to be part of the therapeutic armamentarium of one or two London doctors and was employed in military medicine in the period roughly 1910-1920, before psychoanalysis displaced it, though also remaining outside the British medical schools.

What the medical schools taught in general medicine underwent enormous change and expansion through the nineteenth century, though the roots of change lay earlier in the expanding study of human anatomy and post-mortem pathology. Medicine moved from a whole-body view of illness to the concept of many distinct different illnesses due to single organ or tissue malfunctions. Microscopy, bacteriology, and later biochemistry combined with increasingly detailed inspection and palpation of the patient's body and the use of newly invented instruments (stethoscope *circa* 1820, clinical thermometer 1850, ophthalmoscope 1851, sphygmomanometer 1860, see Castiglione, 1947) to create differential diagnoses and prognoses. Diseases of the brain, the heart, the lungs, the liver, the intestines, and the kidney were distinguished.

Increasingly detailed knowledge, the invention of new instruments requiring skill in use and of tests for normal physiological functioning led to new specialisms and the establishment (in part by laymen) of special hospitals, in the second half of the nineteenth century. The National Hospital for Nervous Diseases, Queen Square, opened in 1860, quickly became a teaching and research centre for neurology, students being admitted to observe specialist practice (Holmes, 1954). Cases without discoverable visceral pathology might be passed by physicians or surgeons to the neurologist, and he in turn, finding no brain or spinal cord pathology, might put them into the category of 'psychological medicine'. Those who specialised in this field were an assortment of private practitioners, some associated with private or charitable asylums, and one or two who became attached to teaching hospitals in big cities (London, Edinburgh, Manchester, Leeds, Newcastle) after 1870. They were described as 'neurologists', or 'physicians in psychological medicine', if they were not general physicians.

Experimental psychology grew out of neurophysiology in the last quarter of the nineteenth century, and in its turn by the end of the century was giving birth to Pavlov's theory of conditioned reflexes from which behaviour therapy would later come, and to the psychodynamic studies of Janet, Freud, and Jung, at first on hysteria but leading to psychoanalysis and analytical psychology (Hearnshaw, 1964). These studies were not the beginnings of psychotherapy, which under the name of 'moral treatment' had been practised for a long time. But psychological handling was simply part of the good doctor's job, not separately categorised or studied.⁴

Pinel had used the words '*traitement morale*' and this passed into direct English. Prichard described 'moral' insanity (1835) meaning insanity with purely emotional (psychological) symptoms without any delusions or hallucinations. Bucknill and Tuke in *A Manual of Psychological Medicine* (1858), the first comprehensive English textbook, described moral treatment (p. 506) as the influence of mind upon mind, arrangements for what they called an *individualised* treatment, where the actual condition of the patient's mind was made the object of study, and ways described of gaining his confidence as a preliminary.

Learning from Books

It is interesting to examine the sales⁵ of the *Manual* and other books on lunacy or psychological medicine, in comparison with the number of doctors employed in asylums and licensed houses. In 1861 the Association of Medical Officers of Asylums & Hospitals for the Insane totalled 152 members, of whom 50 worked in asylums in England and Wales, 45 in private licensed houses, three in workhouse practice, five in the Navy (etc), and 29 in asylums in Scotland and Ireland (see *Journal of Mental Science*, Membership 1861). Somewhat in contrast, Bucknill and Tuke sold 648 copies in three years of the first edition alone, and sales continued steadily thereafter. The Association had been founded in 1841 and was tiny in its first years. Again in contrast, J. C. Millingen's *Aphorisms on the Treatment and Management of the Insane* (1840), a sort of students' pocket book which gave 500 questions and answers in 200 pages, sold 544 copies in five years. Even a specialised work such as R. Brudenell Carter's *On the Pathology & Treatment of Hysteria* (1853) sold 135 copies in its first year, (the author gave away another 54 copies, apart from review copies). J. Forbes Winslow's *Journal of Psychological Medicine and Mental Pathology* which appeared three times a year from 1848 to 1861 (*The Asylum Journal*, later *Journal of Mental Science*, or *British Journal of Psychiatry* dates from 1853) had a steady circulation of about 400, far in excess of all the institutions for the insane at the time.

It is obvious, then, that there was a considerable group of people who were interested in psychological medicine, even though they were not banded into any Society, possessed no diplomas, had attended no organised courses of study and were not themselves attempting to create schools. For some, specialised knowledge may have been the satisfaction of interest, while for others it was useful in legal consultations or for a rich private patient with a mental disorder which was chronic or recurrent. Doctors on their own, either in the provinces or particularly overseas in the armed forces or working for the East India Company in India might well need books for guidance on mental disorder. Applicants for posts as general surgeon in the Company's medical service had to show evidence of at least three months' practical asylum experience in Britain before appointment.

University Teaching

In the early part of this century, Flexner (1912) surveyed medical education in Europe as a basis for American planning, and was very critical of the contrast between Britain and Germany. In Germany, medicine was a university subject, which the State was interested in promoting. Able doctors aspired to be university professors, in the specialties as well as in general medicine and surgery, and they usually had hospital wards and rooms to hand where they could demonstrate cases to students and conduct research. Perhaps in consequence, most of the nineteenth century advances in medicine came from Germany and Austria, and practice in these countries was generally of a high standard.

In Britain, however, there was no Government support of universities or medical schools, and the latter were simply assemblies of senior doctors in private practice who gave most of their time to earning their living, only a

little to their hospital and students, and none to research. There were gifted individuals like Bright, Addison and Gull who made discoveries as young men, but no organisation around them, no facilities provided for any experimentation or research, and no money to supplement their incomes. The general standards of practice were lower.

In the case of psychological medicine, general hospitals would not usually admit these patients (asylums were geographically separate) and were even averse to allowing them as outpatients. When it emerged as a specialism in the 1870s, its specialists were kept out of the clinical schools, and only very gradually admitted into the hospital against the resistance of the general physicians and surgeons.

Guy's Hospital had been forced under the terms of Mr Guy's bequest to house two wards of chronic largely mental patients for about 120 years, until the hospital managed to get rid of them in the mid-nineteenth century. In 1871, however, they appointed (Sir) George Savage, an old Guy's student and leading London specialist, as their first lecturer in Mental Physiology in relation to mental disorder (Cameron, 1954). Only 25 years later was he admitted to the hospital staff as a physician, but up till the day he retired in 1903, was never allowed even to conduct an outpatient clinic, nor have any inpatient in the hospital.

When London University was privately founded in 1826 as a non-sectarian University College, and established a medical faculty, there were at first no clinical facilities. These began with an outpatient clinic in Gower Street, but in 1836, University College Hospital (UCH) was opened (Merrington, 1976), to run on similar lines to the already established London medical teaching centres; i.e., the teachers earned most of their living from private practice. John Conolly, the first Professor of Medicine (1828), was already specialising in mental illness. Like some medical professors elsewhere (Pinel in Paris, Griesinger in Germany, later Laycock in Edinburgh), he went out of his way to provide lectures and clinical experience in this field. However, there were no such patients in Gower Street, and he failed to get his students in anywhere else. He was a provincial physician called to London, and was expected to support his family by London private practice; this was hard on a newcomer, and he resigned his Chair in 1830. He was followed by an established London physician, John Elliotson, already noted for his use of the stethoscope, who had a special interest in hypnotism, therapeutically and experimentally. He upset his colleagues by this, particularly by giving rather theatrical public demonstrations of hypnotism in the hospital – and he had to resign in 1838.

After this, no distinct teaching on mental disorder was given at University College till lectures by W. H. O. Sankey in 1865, with demonstrations at the private Camberwell House, with which he was associated. At this time, only one other London Teaching Hospital, St George's, had such a lecture course (Dr Blandford), but without clinical demonstrations. In 1878, Sankey was followed by W. J. Mickle, the superintendent of Grove Hall, a private asylum in East London, and he in turn was replaced in 1910 by Bernard Hart, from Long Grove Hospital at Epsom, as lecturer in mental physiology and mental diseases. From 1913, after special representations, Hart was appointed a physician to outpatients, but without staff or space: he used an occasionally vacant room in the eye department till 1945, and then a small part of the basement in the Obstetric Hospital. In 1928, he had been allowed to take on assistants in child guidance

and in mental handicap. He retired in 1947, and the NHS reorganisation then brought in 56 beds for psychiatry at the associated St Pancras Hospital, with additional space in a new building later. The undergraduate teaching remained much the same from 1865 to 1948 – a course of lectures, and attendance at a few clinical demonstrations in an asylum miles away, and in later years, optional attendance at outpatients, which few students accepted.

This changed with the NHS, although a Professorial Chair only came at UCH in 1980. It was a long slow struggle to bring psychological medicine into the undergraduate curriculum, – lack of money, of space, and of will, underscored by disgust and fear of lunacy and contempt for those specialising in that field. University College was quite representative of what happened at other medical schools, London or provincial, in spite of the efforts of some notable men.

A Non-University Psychiatric School

The story of the West Riding Lunatic Asylum, opened in 1818 at Wakefield (Todd & Ashworth, 1991) to serve the rapidly growing city of Leeds shows what could be done with a gifted leader. York was the old capital of the North, with a charity asylum from 1777 and the Quaker Retreat from 1796, a medical school (1834-1862) which included a lecturer in mental diseases, and a population who, because of recurring scandals, especially around 1814 in the charity asylum, were alive to the problems of lunacy. The Visiting Committee of the Wakefield Asylum contained MPs active in promoting lunacy law in London and local noblemen with political force; its building and management were strongly influenced by the success of the Quaker Retreat. Their first superintendent, William Ellis was an innovator who introduced occupational therapy, and financial aid to discharged patients.

The new superintendent in 1866 was James Crichton Browne, the son of W. A. F. Browne, a notable Scottish asylum superintendent and Lunacy Commissioner, who had known Charles Darwin as a fellow student at Edinburgh. His son James had a brilliant career at the same university, coming under the influence of Thomas Laycock (a Yorkshireman), a professor of medicine there 1851-1876, who gave special lectures and clinical study periods on mental disorder in addition to his ordinary medical courses and work as a general physician. Crichton Browne graduated MD in 1862 with a thesis on *Hallucinations*, and proceeded to gain experience as an assistant at Exeter, Derby and Newcastle. When he arrived at Wakefield in 1866 he was 26 years old (see Todd & Ashworth, 1991).

He found an asylum of over 1,000 beds with only three staff doctors, and under great pressure for expansion. He told his committee that research must be done to discover the cause of this increasing demand for admission, and that the medical staff was too small. He persuaded them to accept two clinical assistants for three months at a time to undertake the routine hospital work under his guidance, so freeing the staff for time to undertake research. (The clinical assistants were recently qualified men, prepared to work without pay, for board, lodging, and teaching; about 32 were trained by Browne.)

He had a photographic studio built, where patients could be photographed to supply Charles Darwin for his study of *Expression of the Emotions in Man and*

Animals, and the studio was also useful as a pharmaceutical laboratory. Later a pathological laboratory was erected, and regular research started on the morbid anatomy of the brain, involving an extra new member of staff working partly as a pathologist. The first pathologist was Dr T. W. McDowell, who went on to continue his research when he was superintendent at Morpeth and eventually Professor at Newcastle (1910).

Crichton Browne drew in outsiders of distinction. The first was Clifford Allbutt, then a young consultant physician at Leeds, who came regularly and undertook research in clinical thermometry, syphilis, etc.; and then David Ferrier, a young Edinburgh graduate, who had become a consultant at King's (London). He came regularly to Wakefield (by train) because Browne gave him a laboratory, equipment, and experimental animals for research on cerebral localisation – work which became world-famous. (This involved vivisection, then a very upsetting issue in London, and Ferrier may have been grateful for a quiet backwater like the Wakefield Asylum in which to do his research.)

Eminent scientists were invited to lecture, and local practitioners entertained at an annual scientific conversazione. Annually, a Medical Report was published⁶, containing about 12 papers reporting research at the asylum (1870-1876). Their titles indicate a wide range of work, of which neuropathology was to be the most long-lasting. W. Bevan Lewis in particular was the author of numerous papers and books, eventually becoming medical director at the asylum, and (from 1908) Professor at Leeds. Such professorships were largely titular, however, and did not imply any facilities, money, or departments until after 1946.

The expenses of this explosion of work were ignored by the Committee; they were charged to the general running of the asylum, as witness the doubling of the Stationary and Building Accounts during Browne's tenure of office. Browne worked exhaustively till 11.00pm each night (he told Darwin), teaching both local undergraduate and postgraduate students, organising, directing, and writing. When he left for London in 1876, however, his school largely collapsed. There was no money for it, clinical assistants were no longer attracted, and the succeeding directors had neither the energy, charisma, nor wide enough background to carry on. There was no evident educational or scientific institution it could join: Leeds University was still in the future (1904). Only some student teaching for the Yorkshire School of Medicine (Leeds), and the neuropathology survived. What he had done was not repeated anywhere else. There was no demand for it, and no understanding that research needs time to produce results of major practical value.

In London (1876), neurology's time had come, the specialist hospital well established at Queen Square, and neurophysiology (and shortly some experimental psychology) developing at nearby University College. Browne joined with Ferrier, Hughlings Jackson (another Yorkshireman who had been with Laycock), and Bucknill to found the new journal *Brain* (1878), the same year as the *Journal of Physiology*, and encourage the formation of the British Neurological Society (1880-1906 see Neurological Society). For some time, *Brain* continued to publish a proportion of psychiatric papers. At its peak of 253 members, the Society contained about 35 asylum doctors, some physiologists, and consultant neurologists chiefly from the teaching hospitals. Neurophysiology led to experimental psychology: neurologists in France studying hysteria and hypnotism showed how the mental state could alter physical function.

The Role of the MPA

It might have been thought that the Medico-Psychological Association (MPA, 1865) which grew out of the Association of Medical Officers of Asylums & Hospitals for the Insane (1841) might have provided some educational drive. Its *Asylum Journal* (1853), started off with educational intentions, towards architects, magistrates, and other concerned laymen, as well as for the doctors working in asylums. In fact, it proved to be largely concerned with the details of asylum management – how to keep meals hot, organise building maintenance, or judge the latest legal proposals going through Parliament. Editorial appeals for interesting clinical cases or research reports produced very little result. But the Journal did regularly review research and practice coming out of Germany and France. Significantly, Crichton Browne ran his own journals (*West Riding Annual Medical Reports*, then *Brain*) to publish his and his colleagues' work. Forbes Winslow's *Journal of Psychological Medicine* (1848) had closed in 1861.

Individual members of the MPA at times expressed the need for education in the specialty: it should be part of every medical student's schooling said one, the MPA should try to teach MPs, magistrates and others about the realities of mental disorder said another.⁷ But when Dr Woods in his presidential address of 1865 attempted to hold a discussion of the matter, the other Officers blocked it. Dr Sankey returned to the attack in 1868, and Professor Laycock from Edinburgh in 1869.

He personally had started there a three-month lecture and clinical course with an official examination at the end of it, and about a quarter of all his students voluntarily took it. He noted that Dr Skae at the Royal Edinburgh Asylum had been giving regular lecture courses as long as the Army and Navy Medical Boards had demanded attendance there by officers – but the audience evaporated once the Boards ceased to require it.

Thanks to Dr Maudsley, London University had allowed three months' study of mental disorder to count in the required total of a student's hospital practice – but there were no takers. On the other hand Conolly had successfully given systematic lectures and clinical instruction while he was at Hanwell (1843-6). Professor Laycock thought mental medicine was essential for all, and should be compulsory. He advocated that all teaching wards should have attached rooms for mental cases, and that the Association should promote group research on useful treatments.

Sibbald (also from Scotland) returned to the attack (1871), emphasising the importance of clinical instruction, which was so available in Germany and lacking in Britain. It became a recurring theme at annual meetings, until in 1885 there were enough leading specialists lecturing on mental disorder at London, Scottish and provincial medical schools to form an action committee. They recommended that the MPA should issue a certificate of efficiency in psychological medicine to all those passing a special written clinical and oral examination, entry to which would require experience of at least three months' work in some mental institution (the usual time of a clinical clerkship). The first examination was held in 1886 at Bethlem and at the Royal Edinburgh Asylum (different examiners and questions), eight passed at the former, five at the latter, all assistant doctors already working in an asylum.

Members of the MPA hoped that their new certificate would strengthen in

public esteem those who held it, and also raise the medico-psychologist in medical eyes. Magistrates in particular were sometimes contemptuous of the alienist, and might treat a certificate-holder better. They had hoped that medical students generally might be attracted to take the new examination, but this did not happen. It became a certificate for those already working in the asylum world, to help their promotion, and as such accepted a small but steady stream of applicants. Meanwhile, again encouraged by its Scottish members, the MPA began in 1891 (continuing till 1951) regular examinations for a Certificate of proficiency in nursing and attendance on insane persons, with a syllabus for local teaching (in 1893) and a special handbook which ran through eight editions until the 1930s (*Handbook for Mental Nurses from 1923*). This became very successful, in the sense that soon about 600 candidates took it annually (see chapter 10).

With two certificates, the MPA established in 1892-3 an Educational Committee to regulate and run them and explore further development. The Committee recognised that their certificate for doctors was not having its hoped-for success. There was confusion whether it was for students, GPs, asylum doctors, or specialists in private practice. As something run by Association members for themselves, and with a rather restricted syllabus, it made no public impact. They set about widening the syllabus, and approached the Royal College of Physicians to suggest that it might send assessors to the examinations, to endorse the certificates, or collaborate in some way, so that the MRCP could clearly include psychological medicine and indicate this, where appropriate, on the Membership certificate. Both these suggestions failed.⁷

The Era of Diplomas

The Committee then made a study of current examination practice showing how deficient in psychiatric questions the various Finals were, and followed this by writing to all universities to invite them to establish Diplomas in Psychological Medicine (1908-10). It emerged that Edinburgh was already planning one with the heads of various scientific departments, and Manchester was quick to respond (1908-11).

Cambridge, which was already running a very successful Diploma in Public Health (from 1875) and a Diploma in Tropical Medicine and Hygiene (1904), with averages of 40 and 20 diplomates per annum, was favourably disposed to a Diploma in Psychological Medicine. Clifford Allbut, who had been friendly to the Wakefield Asylum 30 years earlier, and had been a magistrate and a Commissioner in Lunacy, was now Regius Professor of Physic at Cambridge, and an enthusiastic advocate. Dr Maurice Craig, a noted consultant in psychological medicine at Guy's, came specially to participate in the launching discussion.⁸ It was noted that the current large asylums were stagnant, with uneducated medical staff who had little chance to learn, and that the MPA, now about 700 strong, wanted to see the start of formal specialist training. A Diploma might be a way of spreading what was known, and encouraging research in what was recognised as a backward and difficult field of medicine. It was decided to start the first examination in June 1912, and try it for five years.

The examination (with some later modification) was to involve written and

practical tests in psychology, and similarly in anatomy and physiology of the nervous system; these would constitute Part I, to be taken at Cambridge, after attending University courses there in anatomy and psychology. Questions on administration of asylums, and on Lunacy Law (which the MPA's certificate exam had deliberately eschewed) would be included. Part II, with two papers and a clinical examination in psychiatry and the same in neurology, would be taken in London, at least two years after medical qualification and at least three months' clinical experience at a registered mental hospital or private licensed house of more than 40 beds. Nine months' attendance on at least two days a week at recognised departments for neurosis, mental deficiency and mental disease, where teaching was given, were also required.

The numbers passing for the Diploma were: 1912 (2), 1913 (1), [interrupted for the war], 1919 (1), 1920 (5), 1921 (5), 1922 (4) 1923 (2), 1924 (1). At this point, the regulations were amended to shorten the attendance in Cambridge to eight weeks, since this requirement was obviously a deterrent. But things did not improve, perhaps because the Maudsley Hospital (London) had opened its doors in 1923, but more likely because the London Conjoint Board (see below) had started its examinations, without requiring attendance at any course anywhere, in 1920. The Cambridge DPM was accordingly abandoned in 1927.

Cambridge had been in a relatively rural situation, with no background of mental illness research or any professor of mental pathology. Leeds, although a new University, was an industrial urban centre, with the West Riding Lunatic Asylum (WRLA) at nearby Wakefield, already a research centre, especially for neuropathology. Its medical director (W. Bevan Lewis) was given the title of University Professor (previously lecturer) in 1908. Its Diploma in Psychological Medicine was established in 1911, with a broadly similar pattern to that at Cambridge, but a special emphasis on the local specialty of neuropathology as a subject of the Part I. The candidate had to be medically qualified for one year before starting on a six months' course which included morbid anatomy of the brain (with practical work, and signed laboratory book). At least six months had to be spent as a clinical clerk, or asylum assistant medical officer in a hospital with at least 500 beds. A research dissertation, or published research in the field, was to be acceptable in place of half the laboratory work.

In 1928, the examination was enlarged into three parts: Part I, to include now physiology of the brain and special senses, Part II, pathology of the nervous system only, Part III, clinical psychiatry and neurology plus experimental and morbid psychology. Candidates had to take the Leeds University courses, on two afternoons in the first term, psychology once a week in the second term and two afternoons in the third term plus Wednesday afternoons at the WRLA. Psychology was taught in the department of education. The course was modified in 1933, 1941, then from 1946 there was a Professor of Psychiatry (not of Mental Diseases) and in 1947 neuropathology was dropped and biochemistry, genetics, pharmacology and social science added, and the clinical subjects widened to include child guidance (psychiatry) and mental deficiency practice. All these courses had to be taken at the University, which may explain the few candidates who entered and passed: three (1912), two (1920), four (1922), one (1924), two (1926), one (1927), one (1928). In 1935, of five candidates, three passed Part I (and two did not), three passed Part II, but all failed Part III, and two passed at the second attempt (1936). In view of all this, the Diploma ceased in 1978.

TABLE 1

1908: Medical students' knowledge of mental diseases on qualification

GMC: teaching desirable, 1885; compulsory for all, 1893

Britain

No questions in Finals:

Oxford, Cambridge, London, Sheffield, Cardiff (Wales), Glasgow, Aberdeen

Conjoint Boards (RCP and RCS) of England and Scotland

possibly one question:

Conjoint Board (Ireland), Royal University of Ireland

one compulsory question only:

Apothecaries Hall (Ireland), Leeds

separate paper (3 questions):

Manchester, Liverpool

separate clinical and oral exam:

St Andrew's, Durham, Trinity (Dublin), possibly Birmingham

Germany

19 universities all have psychiatric clinic, give 6 months' course.

All set questions in finals, students must pass in psychological medicine.

Many students work 3 months in asylum after qualifying.

Graduates of 3 years' standing wanting medicolegal work (coroner, district MO, etc.) must pass special exam. in psychological medicine.

At Manchester the story was much the same: passes were: in 1925, one in Part I, two in Part II; in 1935, one in Part I, and none in Part II; in 1955, five in Part I, three in Part II.

Newcastle College of Medicine (Durham University) which established a Diploma in Psychiatry (DPsy) in 1911, already had a reputation for taking psychological medicine seriously. The GMC, reporting on the Final MB examinations of various schools in 1902 noted that Newcastle was unique in holding a distinct clinical examination in psychological medicine for its undergraduates and praised this. T. W. MacDowell, who had been a neuropathologist at WRLA in Crichton Browne's time, and became superintendent of Northumberland County Asylum (Morpeth) was Professor at Newcastle from 1910.

The regulations set out a formidable syllabus in great detail: anatomy was 20 x two hours, physiology, histology and chemistry were 30 x two hours each, pathology was 20 x two hours (including practical laboratory work), psychology was 25-30 x two hours, clinical neurology was ten demonstrations, and psychiatry ten hours plus six months as an asylum resident or attending there for instruction on at least three days a week. However, there is considerable doubt whether anyone ever took this course (Bettenson – Note 8).

This Diploma was abolished and a Diploma in Psychological Medicine substituted in 1951; Alexander Kennedy had been the first holder of the Chair in psychiatry since 1947. For the DPM, the candidate had to be medically qualified for at least two years, and to have held a resident appointment in general medicine. He/she had to matriculate in the University, and attend courses there, including three months each in psychiatry and neurology. The clinical experience had to include child psychiatry, psychoneuroses, mental deficiency, and a six months' house appointment in neurology (or three months' full-time course as above). In addition to the usual two parts of the DPM, the candidate had to write up ten full case histories of patients under his care, with commentary, and undergo an oral examination on them. The cases were selected with the approval of the Professor, but this was rescinded in 1959.

This diploma seems to have been more successful than most. There was a variable annual entry of 10-20, but it shrank, after the foundation of the Royal College of Psychiatrists in 1971 to only one candidate in 1974 – and was discontinued 1975. In 23 years, 73 diplomates had been created.

The Royal College of Surgeons of England and the Royal College of Physicians of London, jointly in the English Conjoint Board began examinations for the LRCP, MRCS in 1884. In 1920 they also began to hold examinations for a Diploma of Psychological Medicine which were open to Colonial and Dominion (Commonwealth) as well as to British-trained doctors. There were no requirements about attending teaching and lectures anywhere; the requisite two years' clinical experience could be obtained at most hospitals and clinics, and the examinations in anatomy, psychology, clinical neurology, and psychiatry were conservative or even old-fashioned. It quickly became popular: in its first ten years, 173 candidates passed, and in 1931-40 a further 282 (*RCS Calendar*, 1940). After 1949, it was an attraction to Indian and other overseas doctors who came and helped to fill the vacancies increasing among British mental hospital staffs. Even today, 75 years-old, it continues to be held; the syllabus has moved with the times, but the membership examination of the Royal College of Psychiatrists has become the preferred qualification for specialist practice.

In its early years from 1923, the Maudsley Hospital prepared people for the Conjoint DPM, but with the appointment of Professor Aubrey Lewis in 1946, London University was soon creating its own more exacting 'Academic Diploma in Psychological Medicine'. The Maudsley had become the major psychiatric teaching centre in Britain (see Appendix).

Twentieth Century Change

The willingness of universities to consider the teaching and examination in psychological medicine in the first decade of the twentieth century was part of a general growth of medical sciences and of Government concern over medical services. Both were influenced by Franco-German ideas. In 1911, Lloyd George introduced both old age pensions and national health insurance on the German model.

The bulk of the nation's hospitals were then run by the Poor Law, while teaching hospitals and other voluntary hospitals were a relatively small élite. The Royal Commission on the Poor Law of 1905 recognised the Poor Law infirmaries to be grossly impoverished, understaffed and inadequate, but plans developed to upgrade them by transferring them to local government responsibility and this eventually became law in 1930.

The British Psychological Society (founded 1901, its journal from 1906) derived in part from German experimental psychology (Wundt, 1870) and from French intelligence-testing, as well as British neurophysiology and the extraordinary work of Francis Galton on human faculties. From pharmacology came drugs acting on the brain – particularly aspirin (1895), and phenobarbitone for epilepsy (1912). From endocrinology, the importance of the thyroid and adrenal glands, and from biochemistry, the significance of some vitamins and other dietary essentials for mental health became clear.

The work of Charcot in the neurological clinic in Paris, demonstrating

the power of the mind to produce symptoms like those of neurological lesions, and that of Liebault in Nancy to 'cure' by hypnotism, led to new scientific interest in the hands of Janet, Freud, and later Jung. Psychodynamic ideas and psychotherapeutic practices meant a completely different type of medical examination of a patient. In nineteenth century medicine, everything depended on careful physical examination of the body, supplemented by special instruments and testing techniques. But now what the patient had to say, his/her body language and emotions, and reactions to the doctor became the main focus of observation and diagnosis.

This foreign approach, with its appearance of prying into secrets which were discreditable in the judgement of patient and society – particularly if, as they often were, of a sexual nature – met with hostility from both the medico-psychologists of the asylums and from orthodox physicians. It was left to the British Psychological Society, the British Association for the Advancement of Science, and later the British Medical Association to discuss Freudian ideas: the MPA refused to look at them. However, a few private practitioners began to make use of these new concepts; the Lady Chichester Clinic at Hove (1905), the Medical Society for the Study of Suggestive Psychotherapies (1906), the Brunswick Square Clinic (1913-1923), also the Society for the Study of Orthopsychics (1915) (see Hearnshaw, 1964).

The Great War

It was the Great War of 1914-18 which was to change everything. Turning every man up to the age of 45 into a soldier initially meant that women had to go out and work as never before. The murderous static trench warfare in Belgium and France meant hundreds of thousands of dead and wounded, and nearly every family in the country affected by it. It precipitated all kinds of social changes, including public revelation of the brutal, impoverished, stagnant, and hierarchical world inside the lunatic asylums (Lomax, 1923). At the same time, it started a change of view about lunacy.

The Great War could be seen as a gigantic psychiatric experiment which demonstrated that stress could provoke mental breakdown even in the most worthy and well-balanced person, free of all hereditary or vicious traits. It also showed that some mental breakdowns were curable when treated by purely psychological means. However, by labelling the breakdown 'shell-shock' (on the later-disproved hypothesis that the symptoms were caused by brain trauma from the vibrations of exploding shells) orthodox doctors, including neurologists and alienists were able after the war to forget about psychotherapy, and put away the phenomena as irrelevant in peace-time. (See Stone 1985, Merskey 1991, Miller 1940, Ahrendfeldt 1958.)

From early in the war, large numbers of non-physical casualties were being shipped back to England – to asylums and private clinics, and sometimes eventually home – in what seemed to be a permanently disabled state. Officers were more affected than men, some men broke down even before they got to the front line, others only after very long tours of duty. In a battle, these casualties mounted twice as fast as the physical injuries.

The drain on manpower was excessive, the casualties occupied transport and

beds, and the physicians, alienists, and neurologists called into the Army could do nothing about it. But certain academics and psychologists, including peace-time private psychotherapists, showed the answer: early treatment near the front line, using rest, hypnotism, and talk about army life and trench experiences. This was a purely psychotherapeutic approach, which enabled 75% of the casualties to be quickly improved, in some cases returning straight to duty, in other cases first undergoing further military training and regrading. Only 10% (the psychotic, and some others) still had to be returned home. The success of these methods led the Army to establish schools of psychotherapy where more junior RAMC officers would be taught them. In one at Maghull near Liverpool, where Bernard Hart became principal instructor 60 medical officers went through a three-month course in the last year of the war (see Shephard, this volume). Other centres were at Netley, near Southampton, and at Craiglockart (Edinburgh). The scale of 'shell-shock' is shown by the fact that 20 years after the end of hostilities (i.e. in 1939), there were still 120,000 men drawing pensions for psychiatric disability and attending outpatient clinics created primarily to see them. There were also a minority still in mental hospitals at this time.

At demobilisation, the trained RAMC psychotherapists went back to their civilian general practices, but a few returned to, or developed, specialist work. One Maghull trainee, Millais Culpin, was appointed to the staff of the London Hospital, and Bernard Hart himself was at University College Hospital (*vide supra*). But H. Crichton Miller came back with the thought that instruction in psychotherapy must become a part of every medical training, and particularly for the psychological medicine specialist (Dicks, 1970). He hoped to see the medical schools and universities take it up, and got together a band of eminent lay supporters to provide money to open a clinic in London at 51 Tavistock Square. He recruited a group of specialists of his acquaintance who were willing to work for one day a week for nothing, to offer psychological diagnosis and treatment to people who could not afford fees, while at the same time teaching other doctors and doing research (Dicks, 1970).

He had not reckoned with the hostility of orthodox doctors, and no link with teaching hospital, university, or the Maudsley Hospital was forthcoming. Nor were things any better in the other direction. The British Psychoanalytical Society (1919) Ernest Jones' second and more successful attempt to create a Freudian brotherhood preserving the pure word of the Master, was also hostile. This was because the new Tavistock Clinic included adherents of a variety of schools.

The British Psychoanalytical Society gave birth to the Institute of Psychoanalysis (1924) and the London Clinic of Psychoanalysis (1926), and was said to have treated over 3,000 patients by 1976. The Society had been given its own small hospital, the Cassel at Richmond, and a sum of money from an American benefactor; it was therefore able to start its own training scheme of lectures and seminars, personal analysis of the student, and analysis of several cases under an experienced supervisor. This all lasted several years and cost a considerable sum in fees, which it was hoped would be recouped by the earnings of later private practice. The Society was very choosy in whom it would accept for training, and was liable to expel deviants. It went through a crisis in the 1930s when German and Austrian refugees arrived with bitter doctrinal differences – the Germans under Melanie Klein, the Austrians under Anna Freud. For a time, there were two parallel training courses, but a complete split was avoided.

In 1925, the Society had a total of only 54 members and associates, not all medical and only some in practice – the vast majority in London. The American Psychoanalytic Association had 62 members in 1931, and 42 of them in New York City. However by 1957, there were 2754 American analysts, whereas the British-trained were 147 (some overseas) i.e., in roughly 30 years the Americans had multiplied 40-fold, the British only thrice (*Membership*, 1931). There are a variety of explanations for this. One is financial: fewer British patients would be prepared to pay for a treatment involving four or five visits a week for up to several years. Another is organisational. In America, a patient can see a specialist directly, making his own choice. In Britain, most patients first see their general practitioner, who then refers them on to a specialist of his/her own choosing, if he/she thinks fit. In the first half of the century, general practitioners shared a suspicion of psychiatrists in general, and analysts in particular. A third explanation is public attitude. The American believes in improving himself, and has a tendency to try anything new. The Englishman is more inclined to put up with disabilities and make the best of the situation, often distrusting the new.

Thus, since 1920, the paths of British and American psychiatry were quite divergent. Psychoanalysis became a part of American training and medical education, but was excluded from British schools. However, many of the ideas of psychoanalysis, like those of analytical psychology (Jung), and the teaching of Adler and others, seeped slowly into the orthodox courses of psychological medicine. Time, and the appointment of the Tavistock Clinic's director to head Army psychiatry in World War II helped in this. The Clinic became part of the NHS, though without academic attachment. Since 1946, psychoanalysts and analytical psychologists have formed one section of the Maudsley Hospital staff, and over 40 years later, a Chair in Psychoanalysis has been established at University College, London, where Flugel, a founder member of the British Psychoanalytical Society was long a lecturer in psychology.

Since about 1960 psychotherapy has become a respectable subject to practise and teach in Britain, and there are specialist psychotherapists employed (sparingly) in the NHS. But psychotherapy is a much wider subject than psychoanalysis, and includes behaviour therapy, group therapy, family therapy, and cognitive therapy. It is the standpoint of an interview, the methods used in it, which are of main importance; and the particular theory used may be primarily a device to give the therapist confidence (Walker, 1957). More recently, the importance of emotional interaction between patient and doctor has begun to be recognised in general medicine and surgery, through psychosomatic medicine, liaison psychiatry, and the work of Balint and others in general practice.

Both the Institute of Psychoanalysis and the Tavistock Clinic were prepared to train non-medical people in psychodynamics and psychotherapy, and this became important with the appearance of social workers, and educational and clinical psychologists as co-workers alongside doctors and nurses in psychiatric hospitals and clinics. This began in the late 1920s and gathered impetus after 1948, when the new NHS recognised their importance and established posts. But there were also new posts as children's officers, probation officers, and local government social workers where psychotherapy training could be an advantage. In the period 1949-69, the Tavistock Clinic trained 95 social workers and 47 psychologists (Dicks, 1970).

Since the second World War, there has been a multiplication of groups

offering psychotherapy training: the (Jungian) Society for Analytical Psychology (1946) which split off the Association of Jungian Analysts in 1970, the (British) Association of Psychotherapists, training since 1956 and reorganised 1976, the London Centre for Psychotherapy (1973), the Association for Group and Individual Psychotherapy, the Institute of Group Analysis (1971), Association of Child Psychotherapists, British Association for Behavioural Psychotherapy, Guild of Psychotherapists, and other mostly small organisations (see Fine, 1987; Kutter, 1991, Samuels, 1994; Scarlett, 1991).

An attempt has been made to get these societies to combine, at least to the extent of creating a published common register of (approved) psychotherapists, in order to make clear who has had special training and who is only a cult member (e.g., scientologist) or a self-taught counsellor. But there are at least two groupings – the United Kingdom Council for Psychotherapy and the British Confederation of Psychotherapists, vying for power, and psychotherapy seems to be a field of doctrinal disputation. Many of these practitioners are not medically trained, and their work may overlap with what is regarded as medical in the NHS, where one of the unsolved problems is the relationship between the doctor and professional workers of other backgrounds in the field of mental health.

Royal Commission and Mental Treatment Act

The Ministry of Health (established 1919), impressed by Lomax's widely read book of 1923 and by the deficiencies of the Board of Control, and responsive to changed attitudes to mental illness following the War, established a Royal Commission on Lunacy and Mental Disorder in 1924: it produced a revolutionary report (1926).

The Commission was composed of lawyers, MPs, administrators, representative women, and two eminent physicians, but no alienists or psychological medicine specialists. They concluded that they could find no satisfactory distinction between physical and mental illnesses, and thought that all illness should be managed alike. For 'mental illnesses' the medical aim should not be containment and isolation simply of the intolerable (the 'mad', and certifiable) but the offering of treatment to any sufferer, severe or mild, who wished to have it. This should be available anywhere – at home, at an outpatient clinic, in a general hospital or in a mental hospital, depending on available facilities and the patient's needs. Certification, or *compulsory* admission anywhere, should be a very rare event. Doctors dealing with these cases from the whole field of psychological medicine should have adequate special training so that they could work with out-patients and should not be given impossible case-loads nor expected to spend much of their time on administration. Mental hospitals should be small, furnished and equipped to the standards of a good home, with proper provision to each patient of towels, toothbrushes, etc. with cupboards for personal property; while the nurses should be of both sexes and a range of ages, carefully recruited and trained for their work. There was great detail about the care to be provided, and future legal provisions when the 1890 Lunacy Act had been cancelled, but nothing about finance.

The mental hospitals were already run by borough and county councils out

of local taxation as 'free' services, and the Poor Law Infirmarys were about to be handed over to the same authorities to be upgraded into municipal and county general hospitals. The Mental Treatment Act (1930) opened the way to outpatient clinics and even beds in municipal hospitals for psychiatric patients, still as a 'free' service, a forerunner of the full National Health Service. Since the 1930 Act represented a break with the past in some respects, the 1926 Commission created the basis for modern British psychiatry.

Although the changes made possible by the Mental Treatment Act (1930) were slow to develop, the inauguration of the NHS in 1948 transformed the situation. Almost all hospitals, including the mental hospitals, ceased to be a local financial responsibility and became a charge on the national budget, with their staffing organised on a common plan. All would, in principle, have doctors in a hierarchy of training and responsibility from the most junior house officers, through registrars and senior registrars to consultants, although in practice non-training grades of junior and senior hospital medical officers persisted for some time, particularly in psychiatry. They were to be governed not by locally elected councillors but by committees chosen by the Ministry of Health at local and regional level, supported by an executive of professional architects, lawyers, nurses, and doctors.

The effects were threefold. First was money, to compensate for the starvation of the past. Upgrading of long-neglected, out-of-date wards, new buildings to house new departments of acute medicine, social work and occupational therapy, laboratories, proper accommodation for nurses, single and married. The second was a considerable increase in the medical staff of the mental hospitals, with ranks and promotions making a specialist career within the NHS as a psychiatrist possible. Third, differences between the regions encouraged experiment and diverse development – a growth of outpatient clinics, child guidance clinics, day hospitals, rehabilitation centres, etc.

Following the end of the war, many young demobilised doctors took postgraduate training at the Maudsley, and other teaching hospitals, with Government salaries provided to help their civilian resettlement, and some of these came to swell the staffs of psychiatric hospitals.

With these changes came new demands on the service: the wider treatment of depressive illness and of the increase in attempted suicide, the special difficulties of children, adolescents, and the elderly, of alcoholism and drug dependence on the one hand; and the use of new techniques of treatment – ECT, insulin, psychopharmacological (after 1954), group therapy and behaviour therapies on the other. Newcomers to psychiatry were expected to absorb all this by a haphazard voluntary apprenticeship – picking it all up by contact with more experienced staff. Without specific education and training the practical technique of ECT, it was found, could degenerate into a useless or even harmful ritual, while the new psychoactive drugs were sometimes ineffectively used because of ignorance of clinical pharmacology. Apart from the Maudsley courses, few young doctors in psychiatry had access, time, or money to get specialist education. The consultants in individual hospitals varied greatly in their interest in training, and some failed to offer any worthwhile clinical guidance.

Psychiatric Education since 1949

There was, however, now a hunger for knowledge and formal training. Some hospitals began to have occasional lectures by outside specialists, suitable for the whole staff and to which local GPs and others could be invited. Once a year, the RMPA held eight review lectures in London (Maudsley Bequest). The psychiatric section of the Royal Society of Medicine held monthly evening meetings to which people travelled long distances.

But it was left to a few individuals to do more, especially in the 1960s. Dr R. Tilleard-Cole annually hired an Oxford College in the vacation and ran a fee-paying fortnight's residential course of lectures, which were extremely successful. For a number of years, Dr David Watt ran free weekend symposia for the combined staffs of the six Oxford regional psychiatric hospitals on special themes. In greater Birmingham – the greatest centre of population and of scattered hospitals after London – the new staff of All Saints' Hospital in 1961 started their own evening neuro-anatomy course with dissection, as well as psychology lectures by the hospital psychologist, which were joined by many registrars in the Region. Clinical conferences began under the aegis of W. Mayer-Gross (who had retired there). In 1963, W.H. Trethowan, the first newly appointed Professor of Psychiatry organised training in the whole Region (Enoch & Trethowan, 1967).

At Oxford, the first professor only arrived in 1970, and before that the Committee for Postgraduate Medical Studies had set up short courses as afternoon, or evening release, with occasional longer courses for which study leave would be granted. Similar developments began in other Regions. Aberdeen was unusual in having a special psychotherapy course (Millar *et al*, 1968).

Brook (see Russell & Walton, 1970 in Note 9) noted that of all the hospitals recognised as suitable for students to sit the Conjoint DPM, there were in 1965 a quarter with no psychologist on the staff, a fifth with no medical library, and another fifth which never held case conferences. It was clear in the NHS as a whole that, teaching hospitals apart, there was little regular opportunity for postgraduate study of any specialty (including general practice), or for keeping up to date. Setting up a postgraduate medical centre in each area was therefore encouraged, with library and lecture room, and a clinical tutor appointed to run it.

Psychiatric hospitals began to have their own clinical tutors, – usually one consultant – who advised students, arranged events and courses, pressed for facilities, and negotiated with administrators etc. At first honorary and in personal time, the post later carried a fee and a sessional allowance to do the work.

One of the first acts of the new Royal College of Psychiatrists, as they introduced the examination for their Membership, was to set up Appraisal Teams which would visit every psychiatric hospital in turn, to assess the facilities for learning and the general standard of clinical work. Those who did not hasten to improve were not accredited, which meant they would not attract junior staff. The earlier professors of psychiatry had not seen their responsibilities as extending outside the universities to the whole of their Regions. The new ones, though, began to accept that they ought to organise educational opportunities for all the doctors employed in their geographical areas, and those who had

TABLE 2

1966-7: Undergraduate teaching in psychiatry (Britain)

42% of all medical students at a London school.
Professor of Psychiatry at:
all Scottish and provincial universities, 4 Irish schools
4 London Schools (Middlesex, George's, Bart's and the London) only
No professor at:
University College, King's College, Guy's, St Thomas's, Charing Cross, Westminster, St Mary's, Royal Free
(8 London schools)
Other full-time staff:
Scottish and provincial universities have 4 to 9 staff
London: 7 schools have none
5 schools have 1 to 6
London:
6 schools have no inpatient beds for psychiatry, but 6 do.
full 2 weeks' course for all students at Middlesex, Bart's,
the London and St Mary's, only.

themselves trained at the Maudsley had been shown something of what ought perhaps to be provided.

Their primary function, however, was the provision of psychiatric education to all undergraduate medical students. Michael Shepherd and the General Practice Research Group, set up at the Maudsley with the support of the Ministry of Health, had revealed that an enormous amount of psychiatric illness (often unrecognised as such) was being seen and managed only by general practitioners, without referral to any specialist (Shepherd *et al.*, 1966, 1981). GPs needed to know how to recognise and examine such cases, the range of modern treatments available, and how to use the simpler ones themselves.

From 1950 came the era of Commissions of Enquiry and reports on medical education,⁹ of conferences on aims and methods, journals of medical education, and societies such as the Association of University Teachers of Psychiatry (from about 1970). Carstairs *et al.*, in their 1968 study of undergraduate schools, showed enormous variations in what was being offered. Most taught a little about personality development and physiological psychology, but many included much more – conditioning and learning theory, psychodynamics and ethology, human ecology and social science. The total lecture time at Birmingham was 6½ hours, at Newcastle 20 hours, at the Middlesex (the first London school with a professor of psychiatry) 29 hours. Student clerking of an average of seven individual psychiatric patients meant in fact none at Liverpool, and 20 at Aberdeen. Some schools allowed six weeks' full-time clerkship to students in their fifth or sixth year. But opportunities varied for both inpatient and outpatient work and for supervision; the number of psychiatric staff per school also varied greatly.

The use of closed circuit TV and of video, explored particularly at Manchester, has led to the opportunity for all students to see rare or unusual cases; and also to see themselves and others in action conducting interviews, and so to learn what to watch for clinically and how to evoke it. The Manchester course (Goldberg *et al.*, 1983 in Note 9, Symposium), which had to provide for an annual intake of about 260 students, included sequences on social science, statistics, psychology, and epidemiology, offered jointly with other departments in the earlier years of the student's progression. In a clinical year which included a seven-week

psychiatric clerkship (one week of 15 lectures and videotapes to 50 students at a time, plus six weeks in groups of 50 for nine lectures and five outpatient demonstrations, and in groups of six or so for training in interview skills) the whole year also attended lectures on child, forensic, and psychotherapy psychiatry. Whether this is the most effective and useful teaching programme has not yet been decided, but other schools are struggling towards it. Ultimately what is taught to undergraduates may re-define what is needed by postgraduates (see also Association of University Teachers of Psychiatry, 1982).

Envoi

Medical training began as a personal private matter, no more than the doctor needed to earn his living at some level, plus what he wanted to satisfy his curiosity and intelligence. Then the community began to make specialised demands on him: to confirm that a testator was of sound mind when making a will; to care for an isolated group on a ship long at sea, or in a foreign land, or cooped up in an asylum or isolation hospital; to administer an anaesthetic or use new drugs; and so on. New groups in the British population (expanding tenfold to 50 millions) had to have treatment: drug addicts, the old, and children (Pinchbeck & Hewitt, 1973), especially since compulsory national education. So some doctors wanted to acquire this knowledge, and as it became fuller and more complex, it could no longer be simply acquired by individual reading or informed observation, but needed education and training experience in groups (such as a university can provide). The numbers wanting to be taught and practising the specialty had grown enormously. The 1991 membership of the Royal College of Psychiatrists was about 6,000 in the United Kingdom, when there were also non-member psychiatrists in practice. Since 1971, the College has been largely responsible for postgraduate training, as well as representing a large and ever-growing body of specialist doctors to whom it has given an enhanced national status.

Acknowledgements

I am very grateful for help at many points to Jane Boyce, Susan Floate, and Margaret Harcourt Williams.

Notes

1. Oxford Asylum (Littlemore), opened mid-1846, took in 103 patients till December 22: one-third had illnesses such as erysipelas, ascites, hydrocele, hernia, chorea (3), throat injury (2), paralysis (2), bowel disease (2), emaciation (8), fits (11) – Admission Register L5/A1/1/1.

Bucks County Asylum, 1878, had cases of carbuncle, hydatid cysts of liver, gangrene of leg, chronic lupus, enlarged heart, kidney failure – Superintendent's Journal, in Bucks County Record Office, Aylesbury.

2. Growth of Public Asylums in England and Wales

I Numbers: Date of opening, by decades (data from *Medical Directory*, annually)

1811-20 1821-30 1831-40 1841-50 1851-60 1861-70 1871-80 1881-90 1891-01

5 6 6 9 18 12 14 8 10 (Total 88)

II Size of Asylums: numbers in each bed range.

A and B, the same 32 asylums in 1856 and 1895

C and D, all institutions in 1895 and 1939

Beds	<301	301-600	601-900	901-1200	1201-1800	1801-2600
1856 (A)	21	11	—	—	—	—
1895 (B)	-	10	9	6	4	2
1895 (C—all)	4	21	21	12	8	9
1939 (D—all)	3	7	17	21	17	22

Data from the "Medical Directory" (Annual), Section on London and Provincial asylums.

Lancashire and London both had policies of building asylums over 2000 beds.

3. In London, which in time became the dominant teaching centre, producing 40%-50% of all doctors in England & Wales, clinical teaching began at Bart's in 1737, Guy's in 1772, St Thomas's in 1776, the London in 1786, but there were many private pre-clinical schools – Great Windmill Street, Webb Street (absorbed by St Thomas's Hospital in (1842), Dean Street, etc. London University began pre-clinical and clinical teaching at University College in 1828, at King's College in 1829.

In the provinces:

Birmingham, General Hospital 1766, Royal School of Medicine (1836), Mason's College (Science) 1880, joined with medicine 1892. University formed 1903.

Manchester, Infirmary 1752 (Lunatic Hospital 1766), various private pre-clinical schools, Owen's College (Science) 1851, joined with medicine 1873, Victoria University 1880.

[Note: Victoria University added Liverpool in 1884, and Leeds in 1887, but these later split up.]

Leeds, Infirmary 1767, private schools of anatomy (1826) and medicine (1831).

Yorkshire College of Science joined with medicine 1880. Independent University 1904.

Liverpool, Infirmary 1782, Royal Institution School of Medicine 1834, University college (science and arts) 1882, joined with medicine 1884. Independent University 1903.

Similar developments at Bristol, Sheffield, Durham/Newcastle.

Schools also at York (1834-1862), Hull (1832-1869), Exeter (1823-1858) (see Brockbank, 1936).

4. Here is a case report by Daniel Noble FRCS (Lecturer in psychological medicine at the Graham Street School of Medicine, Manchester) in the second edition (Churchill 1855) of his *Elements of psychological medicine: an introduction to the practical study of Insanity, for students and junior practitioners* (pp. 305-6); drawn from the *Gentlemen's Magazine* of March 1787:

In the year 1787 a young woman in a factory at Hodden Bridge, about five miles from Clitheroe in Lancashire, placed a mouse in the bosom of one of her companions who happened to have a horror of mice. A violent convulsive fit ensued, lasting for 24 hours. Other cases succeeded, and in a few days so many of the girls were attacked that the factory work became suspended. A notion sprung up that the disorder had been occasioned by the opening of a bag of cotton supposed, from the apparent results to have been impregnated with something deleterious. Persons at a distance, even, became affected, who had only heard of the malady. Dr St Clare of Preston was sent for, and he conveyed the assurance that the ailment was purely nervous and brought on by imagination, having nothing to do with the bag of cotton. . . . Everyone had unbounded reliance on his opinion and the incipient epidemic was arrested, by an agency analogous to that which had given it origin – the moral influence of Dr St Clare's word.

'Moral' here means psychological, and not anything related to an ethical code. Elsewhere Mr Noble writes 'purely psychical phenomena must be dealt with psychically. The right treatment of uncomplicated insanity therefore is moral.'

5. I am grateful to Michael Bott, Keeper of Archives and MSS, Library of the University of Reading for sending me photocopies of the relevant publishers' ledgers in the Churchill Collection: e.g. Bucknill and Tuke Ledger C445,452; D315, 318; E377 etc. Winslow 1848 vol. 1-8; 1854, 99; 1859, 93 etc.
6. There were six volumes of the West Riding Annual Medical Reports, 12-15 papers in each, and all except vol. 1, over 300 pages long.

Some subjects:

Clinical: puerperal mania; acute delirious melancholia, chronic mania, cerebral injuries and mental disease; the influence of diet on epilepsy, temporary mental disorder after epileptic paroxysms, labyrinthine vertigo (Menière).

Instrumental: the ophthalmoscope in mental and cerebral disease, ophthalmoscopic observations in GPI and dementia, the sphygmograph in lunatic asylum practice.

Treatment: nitrite of amyl in epilepsy, therapeutic value of chloral hydrate, the psychological actions of hyoscyamine, and its use in treatment, the use of opium in treatment of melancholia.

Neuropathology: histology of the Island of Reil, cranial outline of the insane and criminal, histology of the great sciatic nerve in GPI, new method of determining the depth of the grey matter of the cerebral convolutions.

The regular authors included T.C. Allbutt, D. Ferrier, J. Hughlings Jackson as well as Crichton Browne and the staff and clinical assistants.

7. The efforts of the Medico-Psychological Association (MPA). An example of the rank and file opinion: H. W. Rumsey (1867) *Journal of Mental Science* p. 416 and see Renvoize in Berrios and Freeman (eds) (1991) *150 Years of British Psychiatry* pp. 68-70.
 Presidential addresses: Sankey (1868) *Journal of Mental Science*, 14, 297; Laycock (1869) *ibid* 15, 327; Sibbald (1871) *ibid* 17, 305; see also 16, 528.
 Certificates and diplomas: Council discussion (1885) *ibid* p. 276 et seq, p.432-5 and (1887) p. 630-1.
 Education Committee of MPA – Minute books at Royal College of Psychiatrists – March 1893 Vol 1, p. 58, 59, 77 onwards. I am grateful to Mrs Harcourt-Williams, Archivist there.
 For information about the growth in the use of clinical assistants, and a 1890 discussion by asylum superintendents against allowing students into asylums, or encouraging education – see H. C. Burdett (1891) *Hospitals and Asylums of the World*. Vol. 1 and Vol. 2. Appendix B, 248-64, and 200. London, Churchill.
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Appendix

The Maudsley Hospital

This London psychiatric hospital, opened for clinical work and teaching in 1923, has played such an overwhelmingly important part through its first 50 years in the development of British psychiatry that it requires some special account of its history. It represented the realisation and fusion of several long-discussed ideas: that in London, Britain's largest city, there should be one hospital for the treatment of early and acute mental illness only, accepting non-certifiable as well as certifiable cases; that there should be at least one postgraduate psychiatric training centre with university affiliation; and that there should be a central laboratory for biochemical, physiological, pathological and psychological research into mental disorders.

The London County Council, established in 1889 to govern the whole of the greater London area, took over the asylums previously established by the Surrey and Middlesex County Councils and the City, and those created for mental handicap by the Metropolitan Asylums Board. It also began to add to their number in the face of demand from an expanding population. Such an important governing body had a large annual budget and included men of some vision. In the new Claybury (Essex) Asylum, opened in 1893, it took the double initiative of equipping research laboratories (opened in 1895) and of appointing an already noted medical scientist to be their director.

F. W. Mott was both a physician to Charing Cross Hospital and a University College (London) neuro-physiologist who became a Fellow of the Royal Society. He developed important personal research on neuro-syphilis, influenced the clinical staff of the asylum, and directed the work of five staff. He knew it was important to increase the laboratory staff and to offer research training, and tried to do this by using technical scholarships from the LCC's Board of Technical Education, until the LCC's lawyers stopped him by ruling that research is not technical education. He also wanted to offer students the opportunity to work for a London University degree, (but the University would not grant his laboratory recognition, saying that Claybury was too far east of London and away from its centre in Bloomsbury).

Although his laboratory was supposed to collaborate with all LCC hospitals and not just Claybury, it was far away from many of them, particularly a group to the south of Epsom, of which Long Grove (opened 1907) was the latest. He

was therefore keen to move his laboratory towards the centre.

With his knowledge of the working of the LCC, Mott induced Henry Maudsley, a private consultant of great reputation with a London University connection, to offer the LCC in 1908 £30,000 towards the cost of a new acute (teaching) hospital with laboratories. The proposed design had been influenced by their visits to Munich and other German university clinics. The LCC accepted the gift, but did nothing for several years, until Maudsley threatened publicly to revoke the gift, whereupon the LCC in great haste found an open site opposite King's College Hospital in south London and started building (see Allderidge, 1991). It was to cost them three to four times the sum Maudsley had donated, and was ready for occupation in the summer of 1914. Mott moved his laboratories there, but then World War I began, and instead of civilian psychiatric patients, the wards began to take in Army casualties from France.

The hospital for nervous and mental diseases finally came into being in 1923, drawing largely on LCC clinicians previously associated with Long Grove – Edward Mapother as superintendent, with Bernard Hart and three other part-timer consultants. They began to accept groups of LCC asylum medical officers, four at a time for three months clinical teaching each, on secondment, and then to run six-month lecture courses in preparation for the Conjoint DPM. Any doctor in London or the surrounding area could come (paying the fees), on a very part-time basis.

It was confirmed as a University School in 1924, and Mapother became Professor in 1926. The first phase, to 1940 when Mapother died, and the Army again took the hospital over (1939-45), was one of struggle: to raise money to meet important needs, and to find new high-standard recruits to the staff, who could teach and enthuse the students. Among the early needs were a clinical psychologist and a psychiatric social worker; the Commonwealth Fund of America proved sympathetic to those needs.

Dr A. J. Lewis arrived from Australia in 1929 after a Rockefeller Fellowship had taken him to the USA and Germany, while Dr Eliot Slater came in 1931 (with a Rockefeller Fellowship to Germany, in 1933-5) (see chapter 26, this volume). Lewis became Clinical Director of the hospital in 1936, and Professor of Psychiatry in London University at the Maudsley in 1946, and for over 20 significant years thereafter. Thanks to the Rockefeller Foundation, several eminent psychiatrists, refugees from the Nazi persecution in Germany from 1933, found a working home at the hospital, and greatly strengthened the teaching: Mayer-Gross, Guttman, and Alfred Meyer, a notable neuropathologist. In 1949, Erwin Stengel from Vienna was added to the staff as Reader in Psychiatry. A gifted clinical teacher, he later, as Professor at Sheffield, developed a regional service there.

When Lewis became Professor, he helped to negotiate a change of status: the hospital now (1948) joined the British Postgraduate Medical Federation, as the Institute of Psychiatry of London University. About the same time, he was able to effect a union with Bethlem Royal Hospital, the unique medieval mental hospital of the City of London, but now in a modern building only eight miles away. This doubled the number of beds available to 500, provided further laboratory space, and brought financial aid, since Bethlem was rich from London property. In 1967, a completely new building of laboratories, lecture theatres, and offices for the Institute of Psychiatry was added, partly with its help.

Lewis proceeded to widen the facilities. A garden villa (1932) for the acutely disturbed, an outpatient block (1936), and a children's wing (1939) already existed. Now he added jointly with Guy's hospital a neurosurgical unit (1952), the opportunity for students to attend Remand homes and Brixton child guidance clinic, and to enjoy a six-months' secondment to neurology at Queen Square. Wards for disturbed adolescents, metabolic studies, and for old-age psychiatry, an outpatient therapy department with Freudian, Jungian, and eclectic therapists, and an electro-encephalographic department were other developments. In the laboratory sphere, neuropathology was joined by biochemistry, physiology (primarily endocrinological, but later adding instrumental treatment of deafness and of impotence), and pharmacology. Psychology grew to be a very large department and undertook the training of clinical psychologists, as well as cooperating in clinical diagnosis and pursuing research in human and animal psychology.

The laboratories offered opportunities to junior medical staff to undertake research, and sometimes contributed ideas in clinical conferences. But as they grew larger, they tended to split off from clinical psychiatry, depending partly on the interests of their chiefs, and might have worked as happily in a non-medical setting. Collaboration between subjects was not great, and the biochemical, endocrinological, and pharmacological research, while worthy, was not helpful in the psychiatric areas where progress elsewhere was being made – psychopharmacology and neurotransmitter biochemistry, for instance.

Lewis was determined to get away from the Conjoint DPM mentality towards fundamental understanding and imagination. Clinically, he put a premium on careful use of language, and on recording the patient's own words, full investigation of each patient in a systematic way using many informants, and the bringing to bear of exploratory techniques from biological sciences. Each outpatient needed an hour's interview, each inpatient needed two hours at least for a work-up. He saw that education progressed better when students could discuss things with each other, informally and with biological scientists, and that routine clinical work was better performed when careful research (by others) was going on alongside it. It raised aspirations to a higher standard.

In 1953, he established the Academic DPM (London), a three-year course in which the junior staff rotated through a series of six-month appointments. The examination was longer and more intellectually challenging than the Conjoint, and open only to those on the staff of the Maudsley – about 16 candidates per annum. From 1968, the junior staff were strongly encouraged to write short research theses by the end of their three years, and if successful were awarded an MPhil degree, so that the Academic DPM lapsed. Others, and especially the throng of clinical assistants who joined the hospital as fee-payers, not as salaried staff, continued to sit the Conjoint DPM. Some overseas students were given free board and lodging, and additional tuition in peripheral mental hospitals, from Maudsley-trained consultants, as well as coming into the Maudsley frequently.

Apart from lectures the teaching involved weekly ward rounds with individual consultants, and group case conferences, a fortnightly Journal Club to discuss selected recent publications, alternating with a research talk or sometimes a clinicopathological conference. Small group discussions with individual tutors were tried.

The one field in which no experience was offered was in mental hospital

TABLE 3
The 1949/50 Report

The work of the Maudsley Hospital and Institute of Psychiatry			
NHS	registrars training	56	8 on professorial unit (80 beds)
	senior registrars	12	2 " " " " "
Overseas students		54	(Australia 7, New Zealand 4, USA 5, Canada 5, India 7, Egypt 2, Iraq 2, Ceylon 2, etc.)
Total students		185	(on grants and scholarships 26)
Degrees and diplomas awarded in the year			
	Academic DPM	13	
	Conjoint DPM	24	
	PhD	5	
	MD	6	

Department of Psychiatry staff

Professor, Reader, Senior Lecturers 3, research assistants 3
 MRC unit 7, Mental Observation Unit, St Francis, in teaching rotation.

administration and the special clinical problems of such work, and the development of a mental health service. This put the Maudsley graduate at some disadvantage in applying for mental hospital posts. The Maudsley, with its plethora of experience, and highly selective entry for junior staff was felt to be creating an élite, who despised the rank and file working psychiatrists of the country and their often low standards of work. Certainly the new professors of psychiatry and the new consultants of teaching hospitals came increasingly from the Maudsley, but some of the 'élite' did enter provincial psychiatry and began to enliven it by local efforts – as tutors, clinical teachers, and in the encouragement of case conferences and lectures.

For its part, the Maudsley organised several conferences on psychiatric education, reporting on innovations up and down the country and discussing the ideology (see Bibliography to Appendix, Davies & Shepherd). Although the RMPA remained an organisation outside Lewis's influence, their *British Journal of Psychiatry* came to be edited by several Maudsley men: Denis Hill, Eliot Slater, Edward Hare, and a new journal *Psychological Medicine*, founded 1970 and edited by Michael Shepherd, and a succession of books (e.g. *Physical Methods of Treatment in Psychiatry* by Sargent & Slater, 1944; *Clinical Psychiatry* by Mayer-Gross, Slater & Roth, 1954; Shepherd's five-volume *Handbook of Psychiatry*, 1982), and over 20 *Maudsley Monographs* emerged to influence the psychiatric world.

While much of the research coming from the hospital and institute was specialised, two Medical Research Council units with Lewis as Director (Occupational Psychiatry Research Unit, 1948 onwards; Social Psychiatry Research Unit, from 1958) had a very wide effect on British psychiatric practice. The first demonstrated a number of ways in which those disabled by chronic schizophrenia or by mental handicap could be trained to work, and both showed the way to re-socialisation, and provided a basis for the work on rehabilitation, discharge, and the beginnings of care in the community which the mental hospitals began to practice with their long-stay patients from the early 1950s.

Between 1946 and 1964, 417 postgraduate students took the teaching; by

1973, 1634 higher degrees and diplomas had been awarded, and there were 405 staff, with six chairs and seven further titular professors, eleven readerships, and many lesser teachers. Helped by numerous gifts from the University Grants Committee, the Wolfson, Wellcome, and CIBA Foundations, and by the former Bethlem funds, the hospital and institute grew to an enormous size and presented problems of coordination and management. This became apparent after Lewis retired (1966), and his successors, without his peculiar vision and organisational creativity, were left to struggle with a unique, over-expanded, and costly institution.

At the same time, Maudsley ex-pupils were beginning to be able to develop post-graduate teaching and research at other university centres, notably Edinburgh, Manchester, Oxford, and Newcastle.

The success of the Maudsley, in providing training and education, in promoting mental health research, and in changing the practice of psychological medicine by degrees across the country, was due in the first place to money. Without Henry Maudsley's initial gift and some persistence the hospital would not have been built. Without a constant search for funds for special projects, experiments, and research (in particular for staff salaries), the hospital would have been a modest teaching unit comparable with, say, Leeds. Wealthy Trusts like Wellcome were recent ideas, further developed in the USA, and in fact two American foundations, the Commonwealth Fund and the Rockefeller Foundation, were prominent in helping the Maudsley to its feet. Later, when it showed its teaching power, and how it was attracting highly qualified doctors to its courses, it began to get university and State grants, Medical Research Council support, and eventually other medical charities' aid.

Money had to be available, though up till 1908 it really never had been. But again, success depended on the men: Mott, Mapother, Lewis. By good luck, Mott was an able and influential scientist in the right place at the right time. He saw the need to bring research and teaching on mental illness into the University, in contact with scientists in other faculties and with wards and physicians in general medicine, as he had seen it in Germany. He knew also how to go out and get some money. So did Mapother, who bullied the Americans to help, and who realised the need for a large faculty of gifted men as teachers and slowly recruited them.

One, from Australia, was able to build on Mapother's foundations, as fundraiser, as builder of esprit-de-corps with the aid of his formidable critical intelligence, and a distinct vision of what he thought an education in psychiatry ought to be. This was what he imposed on several generations of students. His hospital was a centre of specialist second opinions, a place of thorough careful clinical work, precise thinking, and academic science applied to individual patients, like the best of the London general teaching hospitals. It was not an institution offering a mental health service to a population.

But Lewis was not gifted as an original theoriser, or synthesizer of knowledge. He had no great instinct for the way forward in research, and was inclined to add science department to science department in a somewhat miscellaneous way, hoping that if they were left to themselves, some breakthrough might come out of them somewhere.

The 20s and 40s of the twentieth century were periods in Britain when there was a new concern about and public attitude to mental illness, seeing it as a near universal liability, increasingly a medical specialty and treatable like all

other illness. The coming of physical and pharmacological treatments, some of them successful, in the 30s and 50s supported this new wide view and created the need for specialty advanced training. London had the advantage of metropolitan size over other cities, but it was the particular men, and the money they drew in, which led to the Maudsley's predominance.

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13 Forensic Psychiatry in England: A Retrospective

HENRY R. ROLLIN

In the wake of the sensational verdict in the trial of Daniel McNaughton, *The Lancet* (1843), in a leading article, directed attention to what it described as 'one of the most difficult questions in jurisprudence or in morals'. It went on in the first instance to point up the difficulty of 'determining the precise line of demarcation between the extremes of bad temper, fanaticism, and the commencement of actual insanity'. This problem has always beset, and will continue to beset the forensic psychiatrist, and is one that has engendered, and, no doubt, will continue to engender, heat in the furnace of cross-examination by sceptical counsel. A point is inevitably reached when he demands to know, and has the right to know, if a particular example of deviant behaviour exceeds the parameters of the normal and crosses over into the realms of the pathological. When, in other words, does a man cease to be sane; when does he become clinically mad? It is a seemingly simple, but in fact impossible question to answer, legally speaking.

An equally important problem to which the same leading article also addressed itself is in the case 'where the insanity of the party is indisputable'. It emphasises the difficulty in such a case of 'holding, with a just hand, the balance between the compassion that is due to a miserably afflicted being, and the value of an indefinite number of human lives, which may be sacrificed, immediately, to his hallucinations, or, more remotely, to the contagious example of his misguided acts'. Later in the article, it is contended 'that madness being the most dreadful calamity which can afflict a human being, it would be the height of cruelty for man to raise his arm against one already so awfully stricken by the hand of God'.

The Lancet thus expresses eloquently, in typically Victorian-Gothic prose, the dilemma which has exercised the minds and hearts of society at all times in relation to mentally abnormal offenders, particularly those charged with murder. Does compassion win the day, or does the 'widespread and all but universal cry for blood' hold sway, allowing an unjust verdict to be reached so that the most rigorous penalty of the law may be exacted?

The pendulum in English history has swung between those two poles and it is in the context of this that the historical background between the law and psychiatry in the UK will be examined here. This is best done in the context of *causes célèbres*, most of which have succeeded in bringing about modifications in the law, which

can be considered as progressive in some cases and in others just the reverse. But before doing so, it would be as well to etch in the place of the mentally abnormal offender in our society over the centuries.

Even in the hands of Nigel Walker (1968), the acknowledged authority on the history of Law and Psychiatry in the UK, it is impossible gainfully to probe further back than pre-Norman times. Hard evidence is scant, but Walker put forward a convincing hypothesis, namely that, 'in dealing with serious offences by the insane, such as homicide, (the practice) was to make the offender's family pay and look after him, and this was done without presenting him formally for trial: local knowledge of his insanity settled the matter without the necessity for that'.

In those far off days, life was lived cheek by jowl in relatively static, tiny communities. Any form of deviant behaviour in an individual, including that determined by mental disorder, would be impossible to conceal. Furthermore, in statistical terms, such disorders, no matter how they are categorised, would be few in number and such as did exist would be highly egregious.

It is in the context of such intimate communities, incidentally, that community care, or family care, makes sense, lending added weight to Walker's hypothesis. How families or communities managed to cope with the behavioural problems of their insane brethren is not specifically recorded, but what is certain is that, when occasion demanded, the methods adopted were of necessity heroic; physical restraint was undoubtedly the most common and the most expeditious.

In the succeeding centuries, attitudes towards the mentally abnormal offender fluctuated. Although claims have been made that at the end of the Middle Ages, evil went out of the world and madness came in, there is good evidence that well into the eighteenth century the belief was widely held that the insane were demonically possessed. It was further believed that the harshest possible measures were justified in order to drive the devil out. Even those who rejected the possession thesis construed the insane as marked by God for misfortune, and they were therefore deserving of the same treatment as the bad. In other words, it was justifiable for them to be subjected to beating, exorcism, and the stake.

The Insanity Defence

Central to any study of the history of Law and Psychiatry is the insanity defence, which did not in itself occasion much medical attention before the end of the eighteenth century. Nevertheless, the evolution of the defence of insanity can be traced, albeit shadowily, from the thirteenth century onwards. According to Goldstein (1967) the insanity defence 'refers to that branch of the concept of insanity which defines the extent to which men accused of crimes may be relieved of criminal responsibility by virtue of mental disease'. Because of its inherent complexities, it is the practice of trial judges to explain to the jury the precise terms of this defence during summing up.

In an historical sense, once an offender's mental state became a matter for consideration during his trial, provision had to be found for those whose criminal liability was called into question. These, in short, were the insane.

Recognition of the insane in this context is seen as early as the end of the reign of Henry III (1207-72). H. de Bracton writing at this time describes an insane person as one who does not know what he is doing, and is lacking in

mind and reason. Sir Edward (afterwards Lord) Coke writing in the seventeenth century, includes under the generic term, *non compos mentis*, 'not only lunatics, but persons under frenzies; or who lose their intellects by disease; these that grow deaf, dumb and blind, not being born so; or such, in short, as are by any means rendered incapable of conducting their own affairs. To these also, as well as idiots, the king is guardian'. This, by any standards, is a pretty comprehensive list of infirmities. There are omissions, however, namely, the awareness that it is possible for there to be moral or emotional deficits as well as intellectual ones in the overall concept of insanity. It was not until the end of the eighteenth century that these additional elements were included, since when the insane have been conceived by the criminal law in much the same way as they are today.

Enter the Medical Witness

Although, as already stated, medical men as such were not much concerned as witnesses in trials where the insanity defence was offered until towards the end of the eighteenth century, the defence of insanity in criminal trials had been previously attempted with the assistance of medical evidence. Some had been successful, some not. Walker is at pains to make this clear and cites examples of which that of Lawrence Shirley, Earl Ferrers, is most pertinent. This is an example, perhaps, of the problem of 'determining the precise line of demarcation between the extremes of bad temper . . . and the commencement of actual insanity' (Walker, 1968).

Earl Ferrers shot his steward in a fit of rage and was tried before the House of Lords in April 1760. The accused pleaded insanity. The trial was noteworthy for many reasons, not the least of which was the appearance at the trial of Dr. John Munro, one of the dynasty who superintended Bethlem Hospital for over a century and who featured amongst the earliest acknowledged forensic psychiatrists. However, Munro was at a distinct disadvantage since Ferrers had never been his patient, although his uncle had, and under cross-examination, he was reduced to answering questions in general about the nature of insanity. In conformity with current practice, Ferrers himself conducted his own defence with the help of an earl who acted as adviser, but was placed in the somewhat ludicrous and paradoxical position of using his own wits in an attempt to prove his own insanity. He failed: their lordships, including his adviser, unanimously pronounced him guilty. Ferrers was publicly hanged, the last peer to make his exit in so ignominious a fashion.

Hadfield and his importance

Here, it is justifiable to mention the case of Margaret (known as Peg) Nicholson, who achieved notoriety by making on 2nd August, 1786, a half-hearted and ham-fisted attempt on the life of King George III with an antiquated dessert knife. She was apprehended with no difficulty: the King, with laudable compassion, ordered her to be treated humanely. An investigation by the Privy Council took place, assisted not by one, but two Drs Monro. Peg was found to be insane and on the Secretary of State's order, was committed to Bethlem Hospital for life.

The importance of this case lies in its very notoriety. Since the early seventeenth century, for a variety of relatively minor offences committed 'within the verge', i.e. within twelve miles of a royal residence, manifestly insane patients were sent to Bethlem by Royal warrant, or with a recommendation from the Board of Green Cloth. As Allderidge (1974) points out, such patients were near equivalents to the 'criminal lunatics' of the nineteenth century, but the legality of their detention in Bethlem was, to say the least, dubious.

Peg Nicholson's case has importance as an historical curiosity. Hadfield's, on the other hand, is of prime importance because it highlighted the inadequacies of the law as it stood, and pointed the way towards improvement.

Hadfield, an erstwhile brave and loyal dragoon, was patently mad and there can be little doubt that his madness was associated with, or had been precipitated by, severe brain damage sustained during service in Flanders as one of the Duke of York's bodyguard, all of which must have excited the deepest sympathy on his behalf. There was abundant evidence given at his trial that Hadfield was subject to outbursts of terrifying madness, during one of which he had threatened the life of his own child because he said he had been commanded by God to do so. He entertained the bizarre delusion that, although he must die to save the world, he must not die by his own hand. What better way was there, therefore, than to assassinate the King, thus guaranteeing his own demise? On the 15th May, 1800, he attempted to put his plan into effect by firing a pistol at George III as he entered the royal box at Drury Lane Theatre. Hadfield failed to hit his royal target by a mere twelve inches: he was immediately disarmed by bystanders and arrested.

The charge brought against Hadfield was that of treason and he was brought to trial with remarkable expedition, a matter of only six weeks after the event. He was provided with counsel for his defence, and it was his singularly good fortune that Thomas Erskine, often described as 'the brightest ornament of which the English bar can boast', took the case.

Erskine's defence was masterly. He called a number of lay witnesses to testify to Hadfield's madness, and as a medical witness, called Dr. Crichton (Creighton, as his name is spelt in the transcript of the trial) of Bethlem Hospital who had examined Hadfield at Newgate the night before the trial began. So convincing, indeed, was Erskine's defence that the Lord Chief Justice stopped the trial and directed the jury to find Hadfield 'Not Guilty: he being under the influence of Insanity at the time the act was committed.'

The verdict was fraught with judicial anomalies and difficulties. Hadfield obviously posed a threat to himself, to his family, and possibly to the King, so that it was imperative for him to be detained, in spite of the fact that his detention was patently illegal. Legislation was perforce passed in great haste and made retrospective. It provided that if 'any Person, charged with Treason, Murder, Felony' was found to have been 'insane at the Time of the Commission of such Offence' and hence acquitted, the Court shall '... order such Persons to be kept in strict custody, in such Place and in such Manner as to the Court shall seem fit, until His Majesty's Pleasure shall be known. In this instance, there being no other suitable place, Hadfield was committed to Bethlem Hospital, where, apart from a spell in Newgate following an escape from the hospital, he was cared for until his death in 1841.

The real importance of Hadfield's case is that it provided for a special verdict,

'Not guilty, he being under the influence of Insanity at the time the act was committed'. It created a new category of offenders, i.e. 'Criminal Lunatics' – a wholly undesirable term – and it caused an immediate change in the law so as to oblige the Court, when a person was found insane, to order his safe custody in some suitable place 'until His Majesty's Pleasure shall be known'.

Edward Oxford

The pre-eminence of the sovereign is in itself sufficient reason for him or her to be the target for homicidal attacks by the mentally disordered. Hadfield's attempt on George III differs from others only in that its failure could be measured in inches. Edward Oxford's attempt on Queen Victoria on the other hand, one of several by different assailants, was much wider off the mark.

Oxford, a young man of 18 years when the offence occurred in 1840, undoubtedly knew what he was doing, and as the law stood at the time, this could have been sufficient to result in the death penalty. Indeed, he described in his notebooks how he was to be the instrument of a plot of an imaginary secret society, and to this end, had purchased the pistols and had practised with them.

However, when he came to trial in 1840, Oxford excited a degree of compassion because of his youth and the pointlessness of the attack, made more so by doubts as to whether or not the pistols were loaded. A liberal interpretation of the law seemed more than likely.

Chief Justice Denman allowed evidence in abundance in support of the plea. Lay witnesses testified to the abnormal behaviour of Oxford's forebears, whilst a veritable bevy of distinguished medical witnesses lent their support. Amongst these, surprisingly enough, was Dr. Thomas Hodgkin (of the disease), who described Oxford as having a 'lesion of the will', a nonsensical statement which, nevertheless, went unchallenged. Dr. John Conolly, far less of a stranger to forensic psychiatry than Hodgkin, also gave evidence, but he too, failed to shine. He was compelled to admit that the shape of Oxford's head (phrenology was in vogue at the time) to which he attributed the imperfect development of the anterior part of his brain, was not uncommon in people who were not insane. Because of, or in spite of the medical evidence, the defence succeeded and a verdict of 'guilty but insane' was returned by the jury; this verdict was then incorporated in the Act of 1800, passed to deal with the case of Hadfield.

Oxford, saved from the gallows, was admitted to Bethlem where it is only fair to say he had a distinguished career. Any evidence of insanity that he might have manifested evaporated and never returned. Any suspicion that he was of doubtful intelligence was vitiated by the fact that during his sojourn in Bethlem he became an accomplished linguist and learned to play the violin, apart from showing a distinct aptitude for chess and draughts. Oxford was one of the early transfers to Broadmoor after it opened in 1863, and in 1868 he was discreetly released with the proviso that he emigrated; it is alleged that he changed his name to Cambridge!

Daniel McNaughton

The case of McNaughton (1843), together with those of Hadfield (1800) and Oxford (1840), succeeded in no small degree in transforming the legal concept of insanity in criminal cases from that which had held sway since mediaeval times. What had been brought home, largely as a result of the persuasive eloquence of Thomas Erskine Q.C. in the case of Hadfield and of Alexander Cockburn Q.C. in McNaughton's case, was the malignancy of paranoid delusions. These mental phenomena, they demonstrated, could be powerful and compelling and could affect the behaviour of those subject to them dramatically, and even disastrously.

Nevertheless, the emerging psychiatric enlightenment of this period was not evenly spread, and it is as well to note that between Hadfield and McNaughton there were two comparable cases of deluded killers, Barber (1812) and Bellingham (1812). These were tried in accordance with the older concepts of insanity, were found guilty, and hanged, the latter with positively indecent haste.

Daniel McNaughton, aged 29 years, was the natural son of a Glasgow wood turner of the same name. 'He appears to have been from the commencement a man of gloomy, reserved and unsocial habits', is how Cockburn describes him. Indeed, the way in which McNaughton's mental illness evolved is beautifully detailed in the evidence given at his trial (Rollin, 1977).

There can be no doubt that McNaughton's psychosis would today be diagnosed as paranoid schizophrenia. His delusions of persecution were directed against the Tories and so overwhelming did they become that he determined to murder the Tory Prime Minister of the day, Sir Robert Peel. He made elaborate preparations for the attack which went according to plan, except for one unfortunate mistake: McNaughton mistook his Private Secretary, Edward Drummond, for Peel.

McNaughton was arrested by a constable who had witnessed the attack and was taken to Bow Street Police Court, where on interrogation he said: 'The Tories in my native city have compelled me to do this. They followed me to France, into Scotland, and all over England; in fact, they follow me wherever I go . . . They have accused me of crimes of which I am not guilty; they do everything in their power to harass and persecute men; in fact, they wish to murder me.' Similarly, at the time of the trial, after a considerable degree of persuasion to plead to the indictment, McNaughton hesitatingly admits: 'I was driven to desperation by persecution.'

The importance of this last anguished *cri de coeur* is threefold. Firstly, it shows the compelling nature of McNaughton's delusions; secondly, it leaves no doubt that he knew precisely what he was doing; and thirdly, there can equally be no doubt that McNaughton was aware that he was committing a criminal act, even if in his tormented mind he felt justified (driven) to do what he did. 'The prisoner drew the pistol very deliberately, but at the same time very quickly. It was a very cool deliberate act', said an eye-witness at the trial.

The magnitude of importance of the McNaughton case can be measured by the unprecedented degree of medical involvement. Dr. Edward Thomas Monro, the last of the Monro dynasty to be associated with Bethlem Hospital, examined McNaughton for the defence at Newgate prison. Also present at the examination were Sir Alexander Morison, Monro's colleague at Bethlem; Dr. A. J. Sutherland, physician to St. Luke's Hospital; and Mr. William McClure, a surgeon living

in Harley Street. At subsequent examinations of McNaughton by Monro Dr. Hutcheson, Physician to the Royal Asylum Glasgow, and Dr. Crawford, also of Glasgow, were present. Independently, Mr. Aston Key of Guy's Hospital, and Dr. Phillips, surgeon and lecturer at the Westminster Hospital, had examined McNaughton and gave evidence at the trial.

Dr. Forbes Winslow who later became an established authority in trials where a defence of insanity was raised, was also called. He had not actually examined McNaughton, but had merely been present as a spectator throughout the trial – a circumstance which led to much controversy and was the subject of one of the questions put to the judges by the House of Lords when later the famous McNaughton Rules were framed.

Pride of place amongs the medical witnesses at the trial was rightly given to Dr. Monro who spoke with the authority of 30 years experience on the 'subject of insanity'. His cross-examination was understandably reserved for leading counsel for the defence, Alexander Cockburn Q.C.

'Do you consider that the delusions were real or assumed', asked Cockburn, to which Dr. Monro replied categorically: 'I am quite satisfied that they were real. I have not a shadow of a doubt on the point.' Later in the trial, Monro declared: 'I consider the act of killing Mr. Drummond to have been committed under a delusion; the act itself I look upon as the crowning act of the whole matter – as the climax – as a carrying out of the pre-existing idea which had haunted him for years.'

All the other doctors called to give evidence confirmed absolutely that McNaughton was insane. Dr. Hutcheson, for example, opined: 'The delusion was so strong that nothing but a physical impediment could have prevented him from committing the act.'

The case for the prosecution finally collapsed after the evidence of Dr. Forbes Winslow and Dr. Phillips, who both appeared for the Crown, but both agreed unhesitatingly with the opinions of the doctors called by the defence. The foreman of the jury, without the jury retiring, returned the now famous verdict: 'We find the prisoner not guilty on the ground of insanity.'

After the 'great commotion' created by his crime, and the high drama of his trial, McNaughton's subsequent career was a dull, pedestrian affair. He was duly admitted to Bethlem Hospital and then, in 1864, to Broadmoor Asylum (as it was then styled) where, first in one and then in the other he sank unobtrusively into obscurity. He died on 3 May 1865, aged 52.

The unremarkable post-trial history of McNaughton himself contrasts sharply with the aftermath of his trial. The verdict precipitated a storm of protest in the press and in the highest retreats of the establishment. *The Times* published letters and satirical verses which expressed the feelings of outrage, as, for example, lines such as (quoted by Ormrod, 1977):

On a Late Acquittal
Ye people of England exult and be glad
For ye're now at the will of the merciless mad
Why say ye that but three authorities reign
Crown, Commons and Lords? – You omit the insane.
They're a privileged class whom no statute controls,
And their murderous charter exists in their souls.
Do they wish to spill blood – they have only to play

A few pranks – get asylum's a month and a day
 Then Heigh to escape from the mad doctor's keys
 Ant to pistol or stab whomsoever they please.
 etc. etc.

Queen Victoria herself was most displeased and wrote to Sir Robert Peel, the might-have-been victim of McNaughton's bullet (Benson, 1907):

We have seen the trial of Oxford and McNaughton conducted by the ablest lawyers of the day – and they allow and advise the Jury to pronounce the Verdict of Not Guilty on account of Insanity when everybody is morally convinced that both malefactors were perfectly conscious and aware of what they did . . . could not the legislation lay down the rule which . . . Chief Justice Mansfield did in the case of Bellingham and why should not the judges be bound to interpret the law in this and in no other sense in their charges to the Juries.?

It was impossible for the Government to disregard the volume of public and royal discontent, which was echoed by the House of Lords in its debate of 6 March 1843. As a means of pouring oil on such troubled waters, the Lord Chancellor (Lord Lyndhurst) suggested that an obsolete piece of constitutional machinery be revived so as to enable the House to take the opinion of the judges as to the law of England in the form of answers to specific questions put to them relating to a particular topic. On 19 June 1843, the judges gave their answers which together constitute what is known throughout the English-speaking world as 'the McNaughton Rules'.

Of paramount importance in an historical context is the answer to the second and third questions, namely :-

That the jury ought to be told in all cases that every man is presumed to be sane, and to possess a sufficient degree of reason to be responsible for his crimes, until the contrary be proved to their satisfaction; and that to establish a defence on the ground of insanity, it must be clearly proved that, at the time of committing the act, the party accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing, or, if he did know it, that he did not know he was doing what was wrong.

It is the last sentence, i.e. the 'right/wrong test' that confounded forensic psychiatrists and was to be the *casus belli* between them and the lawyers in criminal trials for over a hundred years. Furthermore, judges were obliged to interpret the law accordingly. In this way, it became virtually impossible for the law of England to develop or to accept the concept of diminished responsibility (which had been accepted in Scotland since 1867) until the Homicide Act of 1957.

The irony invested in the McNaughton Rules is that if the right/wrong test had been applied at the time McNaughton was tried, he could not have been found guilty on the grounds of insanity. It follows, therefore, that the famous Rules constituted a decided retreat from the high ground reached in the McNaughton case itself. Not for the first (or last) time had progress been reversed by the dead hand of public opinion, reinforced in this instance by the expressed wish of a

popular monarch. The 'widespread and all but universal cry for blood' had won the day, as it was to in future trials.

A further example of the same illiberal judgement, possibly influenced by the fact that Queen Victoria herself was the unfortunate victim, is the case of Robert Pate, a former cavalry officer, who succeeded in whacking the royal pate with his walking stick. At his trial, evidence of his mental derangement was given by John Conolly and Henry Monro, both of them leading alienists. The judgement went against the doctors. Pate was found guilty of high misdemeanour and sentenced to seven years transportation.

But two examples *par excellence* of the way the Court chose to set aside the medical evidence because of the extreme violence and barbarity of the killings are seen in the case of Burton, who was tried at the Maidstone Lent Assizes in 1863, and Frederick Baker, who was sentenced to death at the Winter Assizes in Winchester in 1867.

These two cases feature in Henry Maudsley's book, *Responsibility in Mental Disease*, (1906). The first is quoted by him as a case of homicidal insanity occurring when there is 'some defect of intellect, more or less imbecility of mind.'

Maudsley wrote of this: 'It was very simple and very shocking. The prisoner was a youth of eighteen years of age; his mother had been twice in a lunatic asylum . . . ; his brother was of weak intellect, silly and peculiar. He himself was of low mental organization . . . The prisoner said that he had felt 'an impulse to kill someone' that he sharpened his knife for the purpose and went out to find some one whom he might kill; that he followed a boy, who was the first person he saw, to a convenient place.' He then goes on to give in gruesome detail the savagery of the killing in the final act of which 'he trampled upon his face and neck until he was dead. After this he washed his hands and went quietly to a job which he had obtained.' It emerges that Burton knew his victim and bore him no ill-will, but gave as an explanation of his crime that 'only I had made up my mind to murder somebody' and added that he had done what he did because he wished to be hanged.

In their exchanges, counsel for the defence argued that Burton's urgent wish to be hanged was in itself the strongest proof of insanity. Counsel for the prosecution urged that the fact of his having done murder in order to be hanged, showed clearly that he knew quite well the consequences of his act, and that he was therefore criminally responsible.

He was found guilty. Mr. Justice Wightman in passing sentence described the murder as the most barbarous and inhuman that had come under his cognisance in 20 years of judicial experience. He applied the 'right/wrong' test. 'You were perfectly able to understand the nature and consequences of the act which you were committing, and that you knew it was a crime for which by law the penalty was capital.'

Burton, after sentence had been passed, smiled and said 'Thank you, my lord.' His wish was granted and he was in due course executed.

Maudsley, to say the least, was highly critical of the verdict, and disposed of the theory of extreme depravity which was so satisfactory to the judge's mind in Burton's case. He went on, 'There was no need to find a diagnosis of insanity upon the act itself, peculiar as was its character, nor upon the motive of it, insane as that was; through a chain of circumstances the course of the hereditary disease

downwards to its desperate evolution was traceable. Certainly, were it necessary, many cases of acquittal on the grounds of insanity might be quoted, in which the evidence of mental derangement was far less than it was in this sad case.'

The second of Maudsley's two classes of homicidal insanity, i.e. the one in which 'without any manifest intellectual deficit, there has been an insane Temperament' is exemplified by the Alton murder. The culprit, Frederick Baker, was a clerk in a solicitor's office in Alton, Hampshire who came across a group of children playing by the road-side. By some sort of subterfuge he persuaded a little girl, Fanny Adams (who was later to become immortalised in the expression 'sweet Fanny Adams') to accompany him into an adjoining hop-garden where he murdered her and dismembered her body, parts of which were found scattered indiscriminately in the garden. Suspicion fell on the accused, who was immediately arrested. In his desk, a diary was found which contained the laconic entry:- 'Killed a young girl; it was fine and hot.' At his trial, 'only a semblance of a defence was made'. However, a good deal of evidence was adduced as to the mental instability of his father and a near relative, and of his own 'caprices of conduct' together with his suicidal tendencies. It was of no avail: the jury found the medical evidence unacceptable. He was found guilty, condemned to death, and executed.

Maudsley (1906) commented: 'Nevertheless the features of the murder in this case were of themselves sufficient as to produce a conviction in the minds of those who had studied the forms of human degeneracy that there was a strong taint of madness in the murder – that the disease was at least in the stage of incubation.' Maudsley was a convinced Darwinian, and held firmly to the belief that the depraved conduct exhibited in a case such as this was part and parcel of the culprit's pathological inheritance.

But if the decision of the Court would appear to have been arbitrary and illogical in these illustrative cases, illogicality reached new heights in two particular nineteenth-century *causes célèbres*. In these, the murderers appear to have been suffering from what today would be categorised as personality disorders rather than mental illnesses.

The first case is that of James Atkinson, who was tried at York in 1858 for the murder of his sweetheart, May Jane Scaife. The motive, the prosecution maintained, was plain old-fashioned jealousy. The *British Medical Journal* of December 25, 1858, carries a Leading Article, entitled 'Criminal Responsibility of the Insane', which aptly summarises the trial. Dr. Forbes Winslow, one of the witness for the defence, said that 'He (Atkinson) had "the peculiar slouching gait and attitudes of that class of people (subjects of dementia). . . .' Had he met him in a room he would have been much struck with his appearance.' A second medical man, Dr. Caleb Williams had 'no doubt that he was an imbecile', and a third, Dr. Kitching, who had attended his family for years, 'classed him as an imperfect idiot and partial imbecile'. The evidence of lay witnesses for the defence served 'to substantiate the imbecility of the prisoner'. They indicated that he had a tainted hereditary – that he had shown life-long violent and anti-social behaviour.

There was one dissenting medical voice, that of Mr. Anderson, the surgeon of York Gaol. The writer of the Leading Article, with a degree of forthrightness which seems to have been common in those days, blasts Mr. Anderson with both barrels. 'We own, however, that we are greatly surprised that Mr. Anderson . . . ,

whose experience of lunacy must be of a very limited nature, should have had the hardihood and the bad taste to abuse his medical brethren as he did' – and there is more in this vein.

Nevertheless, in spite of the overwhelming medical evidence for the defence, Mr. Price, the counsel for the prosecution had the audacity to advise the jury 'to reject the testimony of a set of hired advocates in that profession who want to prove the theories of their own crotchety brains.' In the event, the defence won the day: the jury returned an insanity verdict and Atkinson was committed to Bethlem.

Roger Smith (1981) discusses at length the serious repercussions of the verdict in the Atkinson case. The sympathetic attitude of the *British Medical Journal* towards the medical defence witnesses was not shared by other leading alienists, who believed that the specialism had been brought into disrepute. The critics were to be supported sometime later by Dr. W. C. Hood of Bethlem, who had occasion to write in Atkinson's case notes, 'It is quite impossible to understand the medical evidence given at his trial, in favour of his being of unsound mind.' He went even further: when he had occasion to write to the Chairman of the Commissioners in Lunacy in 1869, he included Atkinson amongst several of his criminal patients who showed no signs of insanity. Smith comments: 'This statement confirmed the view that the insanity defence was an "escape" for criminals and therefore a danger to society.' Perhaps the most grave repercussion was that: 'It particularly damaged the proposal to establish a specialist panel of alienists as an instrument of the Court.' Whether such a panel would have worked in practice is a matter for debate, taking into account the difficulty in obtaining a consensus among psychiatrists on almost any matter.

But it is important to illustrate further the extent to which opinion about the Atkinson case was divided within the medical profession, even amongst those who laid no claim to be experts in the field of mental illness. No less a medical luminary than Dr. Mayo, President of the Royal College of Physicians of London, wrote to *The Times* (his letter is reproduced in the *British Medical Journal* of 1 January 1859). He attacked, in particular, Dr. Forbes Winslow: 'The argument of Dr. Forbes Winslow would not, I imagine, have satisfied the Commissioners in Lunacy that vice, cruelty, intemperate passionateness, defective memory, feeble moral qualities, and limited intellect, inadequate notions of the nature of the Deity, even accompanied by a goitre would warrant their depriving Atkinson of his liberty.'

Dr. Winslow was well able to look after himself. In a letter dated December 24, 1856, also addressed to *The Times* (reproduced in part in the *British Medical Journal* below that of Dr. Mayo quoted above), he writes, 'If these symptoms were considered individually, they would be unsafe and dangerous evidence upon which to form a conclusion as to the state of any mind; but when viewed in the aggregate, they constitute valid and satisfactory data to guide the medical jurist to a right result.'

Winslow concludes his letter with a passionate plea to the effect that if Dr. Mayo and those who share his opinion had their way, then 'they would be able with impunity to indulge their fancy and gratify their tastes, by witnessing many a poor irresponsible lunatic strangled publicly to death upon the gallows! God forbid that such a demoralising, degrading and brutalising spectacle should ever be witnessed in a civilised and Christian country.'

But if the Atkinson case created more than a modicum of consternation in medical and public circles, it was as naught compared with the storm created by the second of the *causes célèbres*, that of George Victor Townley. It would be no exaggeration to compare Townley with McNaughton in this context: in socio-historical terms, they are in the same league.

Townley in 1864 savagely stabbed his fiancée, Miss Goodwin, to death after she had jilted him in favour of another suitor. He made no attempt to cover up his crime: On the contrary, when apprehended, he stated quite bluntly, 'She has deceived me; and the woman that deceives me must die. I told her I would kill her. She knew my temper.' He was tried at Derby.

The ubiquitous Dr. Forbes Winslow was again the chief medical defence witness. His defence was insanity, in support of which he put forward the proposition that there was in Townley an inherited predisposition to insanity which was linked with his manifest excitability and excess of temper. Ergo: Townley was morally insane.

It is of interest to interpose at this point the view of Dr. James G. Davey, given in a paper read at the Bath and Bristol Branch of the British Medical Association meeting in Clifton in February 1864 (*British Medical Journal*, April 1864, pp.392-3). He came down very firmly on the side of Forbes Winslow:

Townley came into the world minus the essential elements of mental health; his parents transmitted a certain predisposition of mental disease. Without the normal elasticity of mind, Townley was, or is, without the power to bear the heavy blows; and he succumbs to it ---- we, as medical men, are driven to the conclusion that Townley killed Miss Godwin under the influence of a paroxysm of impulsive and homicidal mania.

However, at the trial, the defence failed; Baron Martin directed the jury in terms of the Rules, and within the remarkably short space of five minutes, they returned a guilty verdict. This gained popular approval: it was felt that for such a brutal, spine-chilling murder, justice had been done, but the tragi-comedy now begins. Baron Martin immediately after the trial wrote to the Home Secretary, Sir George Gray, saying that, in his opinion, Townley's conviction was just, but that two doctors had declared that he was absolutely insane. The Lunacy Commissioners were requested to examine him. This they did and their stated opinion was that although not of sound mind he was, nevertheless, responsible within the meaning of the McNaughton Rules.

Townley's family was both well-to-do and supportive; they could afford the best lawyers available. A certificate of insanity signed by two doctors and three justices was produced, and Lord Normanby's Act of 1840 was invoked. On the strength of this, the Home Secretary decided to respite; with only 48 hours to spare before the time fixed for his execution, Townley was transferred to Bethlem. Then, the protests were immediate and deafening with the press universally condemning the Home Secretary's intervention. The *Manchester Guardian* howled; 'The professional "mad doctors" let us repeat, would acquit us all of guilt and convict us all of insanity; we protest against their extravagance', a protest to be heard repeatedly even to this day. The medical establishment, through its mouthpiece, *The British Medical Journal*, joined in the chorus of disapproval – surprising, perhaps, if one recalls the sympathetic stance it took in the case of Atkinson. A leader (January 9, 1864), headed 'Townley, The Murder', was written in vitriol rather than in ink,

'For our own part, we cannot do otherwise than regard this respite of Townley as the beginning of the end of capital executions in this country – a deep cry of Humanity's Voice. It must be clear to every one of us, and certain as the day, that if Bill Sykes had done this murder on Jane Scroggins he would be already hanged on the gallows: and that Townley's life has been spared simply and solely because he was able to pay an expert's fee. – But then, where is equal law? If Townley hang not, why should Sykes?' And there is much more in this vein. The beginning of the ultimate paragraph, for example, reads: 'Was every such a trick or farce played upon British criminal law – justice so turned upside down and put to such complete ridicule?'

But it was not only the medical establishment that turned its back on the respite granted to Townley: the 'mad doctors' themselves broke ranks and some, particularly Maudsley and Lockhart-Robertson, attacked Forbes Winslow and publicly disowned his criteria of insanity.

The hapless Home Secretary, although he had the law on his side, was only able to quell the hysteria that abounded by ordering yet another examination. The *British Medical Journal* (February 6, 1864, p.159), in a leading article, rejoiced in the outcome: 'The opinion so often repeated in this Journal, that if ever a murderer ought to have been hanged according to law, Townley was the man, has now found the fullest confirmation. Drs. Flood, Bucknell, Meyer, and Helps have examined the man in Bethlehem (sic) Hospital and have unanimously certified that he is of sound mind'. The sentence on Townley was commuted to penal servitude for life and he was transferred to the penitentiary at Pentonville. Shortly afterwards, he rang down the curtain on what must be one of the most tragic farces in British judicial history by taking his own life.

The epilogue to this strange, eventful history is noteworthy. In an outburst of enlightened self-interest, the Act of 1840, which had forced the Home Secretary to reprieve Townley was amended by a bill quickly introduced.

The Homicide Act, 1957, and after

It is no flight of fancy to say that, historically speaking, the relationship between the Courts and the doctors is, and always has been, worse than that between the Courts and any other profession or class of expert witness. 'Abolish capital punishment, and the dispute between lawyers and doctors ceases to be of practical importance', said Henry Maudsley in 1874. Not for the first (or last) time did the omniscient Maudsley prove to be wrong. The wrangle continued even after capital punishment was suspended for murder in 1965.

These same fervent hopes for an amelioration of the situation had been expressed when, belatedly, the concept of diminished responsibility was introduced in the Homicide Act, 1957, but to little avail. Indeed, Dr. Hugo Milne, one of the forensic psychiatrists to be 'crucified' by counsel for the prosecution when he gave evidence on behalf of Peter Sutcliffe at his trial in 1981, condemns the Act out of hand. In an interview in *The Observer* (29 April 1984) he said that the law on criminal responsibility was, 'an unworkable piece of legislation which had been abused to such an extent that it makes a mockery out of the very term mental illness', and he went on to claim that it was 'widening rather than lessening the gap between the law and medicine'.

The Case of Peter Sutcliffe

It is in the context of Dr. Milne's criticism of the Homicide Act that it is imperative to examine the vitally important case of Peter Sutcliffe. Not only did it create more public alarm than any other case this century, but the trial struck a new low in the relationship between forensic psychiatrists and their legal counterparts and a new high in the importance given to the dictum, so beloved of lawyers, that, 'In England, we have trial by jury and not trial by doctors'.

Peter Sutcliffe, nicknamed 'The Yorkshire Ripper', was, after a particularly ham-fisted police investigation, arrested and charged with the murder of 13 women and the attempted murder of 7 others over a period of years. He was tried at the Central Criminal Court, Old Bailey, on 22 May, 1981. Four eminent psychiatrists, two for the prosecution and two for the defence agreed (and this in itself is no mean accomplishment) that Sutcliffe was mentally ill and that paranoid schizophrenia was the probable diagnosis.

Sir Michael Havers, the Attorney General, leading counsel for the prosecution, offered to accept the plea of manslaughter on the grounds of diminished responsibility in accordance with Section 2(1) of the Homicide Act, 1957. The implication of this plea was that at the time of the killing he (Sutcliffe) was suffering from such abnormality of mind, (i.e. schizophrenia), induced by disease, as substantially impaired his responsibility for his acts. The virtue of the acceptance of the plea would have been to spare the families of the victims the ordeal of listening to the sickening details of the killings in Court or in the press (his nickname gives a hint as to the nature of the injuries inflicted by Sutcliffe on his victims).

Mr. Justice Boreham, the trial judge, thought otherwise. He undoubtedly sensed the 'widespread and all but universal cry for blood' on the part of the public. On his insistence, a full trial was demanded so that the jury would be able to evaluate the psychiatric evidence on which the diagnosis was made. As a result the lawyers, who had been prepared to concur with the psychiatrists, were now compelled to break ranks and assume their customary adversarial stance. Once the fight began, it became evident yet again that the fragile discipline of psychiatry is no match for the heavyweight onslaught of the lawyers. The psychiatrists had a very bad time: they were mauled in the witness box and in the press. Typical of the press comments was that of *The Police Review* (1 June 1981) which read, 'four eminent psychiatrists were made to look such asses in the witness box, with their apparent support for the story that Sutcliffe had been retained by the Holy Ghost for the purpose of killing off prostitutes'.

Of far greater importance perhaps was the comment of *The Times* (May 23, 1981) which, it will be remembered, was reduced to thunder its feelings of outrage in satirical verse following the trial of Daniel McNaughton (see p.248). In similar vein, it condemned Sir Michael Havers for accepting the view of the psychiatrists, and went on to allege that the trial was, 'a public catharsis, an exorcism, and it was right to strip the mystery away in court and in print, both to give the amplest possible reassurance to people in the cities where the Ripper had become an obsession to an extent outsiders hardly appreciate, and to satisfy a public curiosity which is more than gloating.'

The jury found Sutcliffe guilty of murder: the opinion of 12 men and

women on the Clapham omnibus was preferred to the unanimous opinion of four acknowledged experts. In effect, psychiatry itself had been on trial and had been found sadly wanting. But the public, it was felt, had had their catharsis, their exorcism; their cry for blood had been met *grâce à* Mr. Justice Boreham.

After the verdict, the mandatory sentence of life imprisonment was passed with a recommendation that Sutcliffe serve a minimum of 30 years. He was committed to the high-security wing of Parkhurst prison on the Isle of Wight. An appeal in the Court of Appeal was refused: their Lordships declared that they 'found nothing unsafe or unsatisfactory, in the murder verdicts'. They held that Mr. Justice Boreham had been right to order that the issue of Sutcliffe's medical state be tried by the jury. 'It is, in the end, of the greatest importance that trial should be by jury and not by doctors or by counsel', Lord Lane, the Lord Chief Justice pronounced. He went on to say: 'We take the view that where there is room for a genuine difference of opinion of the facts of this nature and importance, generally speaking it is better left to a jury to decide the issue'. He concluded his diatribe with this *coup de grâce*: 'particularly as there is a suggestion that the doctors had been hoodwinked by the defence'.

It was not too long, however, before the psychiatrists at the trial were completely vindicated. Sutcliffe's mental condition deteriorated: any possible doubt about the nature and depth of his psychosis evaporated: he was eventually transferred to Broadmoor special hospital under the provisions of Section 72 of the Mental Health Act, 1959. There he remains to this day.

Post-Sutcliffe

Since this twentieth century *cause célèbre*, there has been a marked tendency for judges in English courts to leave it to the jury to decide the issue of diminished responsibility in trials for murder.

For example, in 1984, Dennis Nilson was tried for murder at the Central Criminal Court, Old Bailey, in a case of spinechilling gruesomeness. He admitted to having killed 15 young men and to have made a further 7 attempts at murder between 1978 and 1983. As happened in the case of Sutcliffe, the Judge refused to accept a plea of manslaughter on the grounds of diminished responsibility and insisted on a full trial. Three leading forensic psychiatrists, two for the defence and one for the prosecution, suffered a fate no less humiliating than did those at the Sutcliffe trial. Nilson was found guilty of murder and sentenced to life imprisonment, with a recommendation that he serve a minimum of 25 years.

In 1986, Milla Beechhook was tried for the murder of two children. The jury were unimpressed by the lengthy psychiatric evidence and found the accused guilty. She was awarded two life sentences. Again, in December 1986, Errol Walker was tried at the Old Bailey for murdering a mother and the attempted murder of her daughter. An eminent forensic psychiatrist gave evidence that Walker was mentally handicapped, but the jury were unmoved and rejected the plea of diminished responsibility. He was found guilty of murder, and was jailed for life.

John Steed, the 'M4 Rapist'

The importance of this notorious case is that it reversed the tendency to leave the issue of diminished responsibility in murder trials to the jury. This case, like that of Sutcliffe and Nilson, occasioned the deepest public alarm. John Steed, (one of his many aliases) aged 23, dubbed the 'M4 Rapist' was responsible for a veritable reign of terror in southern England, during which he carried out a series of appalling rapes and sexual attacks on young women in the autumn of 1985. He was finally arrested after the murder of a prostitute in London's West End.

At his trial in November 1986, at the Central Criminal Court, Old Bailey, his plea of guilty to manslaughter on the grounds of diminished responsibility was accepted. Reports from three forensic psychiatrists, one for the prosecution (myself) and two for the defence, were submitted to the Court and all were of the opinion that Steed was a psychopath. In support of this contention, it was revealed that Steed's history was a 'text-book' one, and left little doubt as to the authenticity of the diagnosis. From an early age, he had shunned affection and, according to a family friend, 'was a strange bloke, never any good at relationships. As a boy he wouldn't even accept a cuddle from his own mum'. Steed had a lengthy criminal record going back to 1975, his offences including thefts, robbery, assault, stealing cars (at which he was particularly adept), possessing offensive weapons, and indecent exposure. Of unusual interest perhaps is his pre-occupation with body-building, in the course of which, it is alleged, he used anabolic steroids. He idolised the film star, Clint Eastwood, and the tough-guy characters he portrayed, all of whom he attempted to emulate. He was an ardent Zen Buddhist and heavily tattooed with animal symbols of that religion. Mr. Allan Green, counsel for the prosecution, agreed that Steed was suffering from a psychopathic disorder and commented; 'Where medical evidence is all one way and the quality of that evidence cannot be impugned and there is nothing in the case which can justify a contrary view, as in the Sutcliffe case, the evidence should be accepted.' The trial judge, Sir James Miskin, the Recorder of London, when addressing Steed, emphasised that, 'not one of the doctors recommends medical treatment and not one says you are safe', and when passing sentence he declared, 'You represent such a danger to the public, especially to women, I have no hesitation in passing life sentences for each rape and for the manslaughter'. Steed received, in fact, 4 life sentences plus 20 years imprisonment.

What is of vital importance about this trial, which received maximum coverage in all the media, is that it appears to have passed off without any indication that the public had been robbed of their exorcism or their cry for blood. In this case, at least, it seemed unreasonable to the learned judge to test expert psychiatric evidence against the lay opinion of 12 men and women on the Clapham omnibus, just because public feelings were running high. This was an opinion in stark contrast to that expressed by the trial judge, Mr. Justice Boreham, and subsequently the Lord Chief Justice, Lord Lane, in the trial of Peter Sutcliffe, a mere four years previously.

The relationship between lawyers and psychiatrists

It is evident that since records were first kept, the relationship between the legal and medical professions has not always been noted for its friendliness or, indeed, mutual respect. The fault may lie in the ineptness of the medical witnesses as, for example, the nonsense talked by Dr Thomas Hodgkin in the trial of Edward Oxford (p.247), or the less than brilliant performance of Dr. John Conolly in the same trial. An example of the ferocity of the attack on a medical witness was the plea made to the jury in the trial of James Atkinson by his defence lawyer, Mr. Price. He begged them 'to reject the testimony of a set of hired advocates in that profession who want to prove the theories of their own crotchety brains'. However, nothing could better illustrate the precariousness of the position of the medical witness in trials for murder as relatively recently as the late 19th century than the letter to *The Lancet*, dated 25 February 1888, and the report in the *Journal of Mental Science*, dated April 1888.

The first was written by Dr. Forbes Winslow, a frequent witness in murder trials, who may be considered a founding father of forensic psychiatry as we know it today. He drew attention in the most restrained terms to the exactly opposite rulings given by Mr. Justice Mathew at Maidstone and by Mr. Justice Day at Leeds. Winslow expressed his deep concern as to who is better qualified to give an opinion, where the plea of insanity has been raised – the jury or the medical expert.

Medical Witnesses in Lunacy Trials

To the Editors of *The Lancet*

Sirs, Medical men are placed frequently in a difficult position when being examined as experts in lunacy cases. This is much increased by the difference in opinion which exists among judges as to what may be given by them in evidence, and allowed to be admissible. This was made most evident in two cases which occurred during last week. I was present on *subpoena* as witness in the Ramsgate shooting case tried at Maidstone before Mr. Justice Mathew. In this case the question of ability to plead was primarily raised. The medical men examined were asked whether in their opinion he was of unsound mind. When being arraigned for his trial, and on their giving the answer in the affirmative, the jury so found. Immediately the case was over, I went down to Leeds to give evidence in another trial of a similar description. On my arrival, I found that Mr. Justice Day had ruled exactly opposite to what I had heard Mr. Justice Mathew rule at Maidstone. I give the shorthand writer's notes. Mr. Waddy, counsel for the prisoner, asked Dr. Clifford Allbutt, who was retained as well as myself in the case, 'Was he in your opinion, sane or insane when examined this morning?' To which Mr. Justice Day remarked: 'Experts are not to be asked questions which the jury are sworn to try. You may ask matters of fact as to what he saw or heard, but you must not ask him whether he is sane or not. I am not laying down this point with respect to this particular question of insanity, but I lay it down as a rule by which I shall always be guided in all cases when scientific or expert witnesses are called to give evidence.' I think the time has come when medical men should know what they may say in cases where the pleas of insanity has been raised, and not, when they arrive on the scene, find they are prohibited from expressing their legitimate opinion for fear of interfering with the prerogative of the British jury, who are stated to be the proper persons to decide the vexed and complicated question, and

not the medical expert. The importance of the subject is my excuse for troubling you with this communication.

I am, Sirs, faithfully yours,
L. FORBES WINSLOW, D.C.L.Oxon
Wimpole-street, W., Feb.22nd, 1888

The Lancet, 25 February 1888, 396

In the second, the report draws attention to the same dilemma, but points up in no uncertain terms the depths to which the judiciary may sink in their attack on 'medical gentlemen'. Mr. Justice Field in his final rebuff of the hapless Dr. Needham, 'He could no more dive into a man's state of mind than I can', must live for all time as prime examples of 'studious rudeness' and of elephantine judicial arrogance and conceit.

Now comes the extraordinary feature of the case from the judicial point of view. Mr. Justice Field, in addition to treating the medical witnesses with studious rudeness, refused to receive their opinion as to the sanity of the prisoner. When Dr. Needham had given his evidence and expressed an opinion that he was insane, his lordship said he was determined not to allow a medical gentleman, however eminent, to be substituted for the jury. Again, when the gaol surgeon was asked whether he formed any opinion as to what the prisoner was suffering from, and he replied that when first brought in he thought he was imbecile, the Judge objected 'that is answering the question that I did not wish you to answer'. When counsel asked whether he might inquire whether the prisoner was suffering from disease, his lordship replied, 'Bodily, Yes; mentally, No.' When Mr. Bucknill suggested that the opinion of a medical man regarding the prisoner's state of mind now might assist the jury in arriving at a conclusion as to his state when the act was committed, Mr. Justice Field said, 'I shall rule clearly not. The jury see what his conduct and appearance are and have been. I don't see that the opinion of a medical gentleman carries it a bit further. *He could no more dive into a man's state of mind than I can*'.

Journal of Mental Science, 34, No.145, April 1888

It might be as well to examine in a little more detail the reasons for this antipathy between the two learned professions, and what is more, the suspicion with which the laity from Queen Victoria downwards held the growing forensic trend, which seemingly allowed indicted murderers to escape the gallows (this was, of course, before the abolition of capital punishment).

It may well be that 'alienists', as practitioners of 'mental medicine' were then called, were poor witnesses who were served up as sitting ducks for the lawyers during often aggressive cross-examination. To begin with, the doctors were (and still are) out of their element, and feel intimidated in the witness box in, say, Court No. 1 at the Old Bailey, the most famous criminal court in the world. Experience, as I can personally vouchsafe, may dim but can never quite extinguish the anxiety which attends such occasions.

But if ineptitude in the context of legal procedure made them poor witnesses, their frailty was substantially increased by the implausibility of some of their arguments. The courts were sceptical about the inclusion of emotional and/or volitional disorder as factors in criminal acts, particularly murder, although they

were willing to accept physical disorder of the nervous system, or demonstrable phrenological or physiognomic abnormalities (phrenology and physiognomy were much in vogue in earlier days). Similarly, the courts were at home with depression, either post-partum or associated with menstruation, and would accept the compelling nature of delusions. Again, alienists were criticised because of the circularity of their arguments as, for example, that because an act would appear to be insane, it followed that the perpetrator was himself insane. Furthermore, courts were sceptical about the fine distinction between irresistible impulse, sometimes pleaded, and unresisted impulse.

Of paramount importance, however, is the fact that forensic psychiatry as a specialty did not exist, except perhaps in its very embryonic stage. There were individual medical men drawn from the general body of medical practitioners or from those working in prisons, who appeared from time to time in criminal cases, but they did not belong to a cohesive group. There was no corpus of knowledge on which they could draw; there were no academic meetings of like minds, no journals for the exposition and interchange of ideas, and no formal training. They were in effect amateurs, pitting their slender skills against the full weight of the professional full-time lawyers who, it might be added, enjoyed the distinct advantage of always playing at home.

The evolution of the forensic psychiatrist of today

In the course of this chapter, I have mentioned the names of medical men from the late 18th century onwards who have played their part, large or small, with distinction or otherwise, in the drama of the court room, particularly in trials for murder. Together, in an amorphous sort of way, they pioneered what has come to be recognised today as forensic psychiatry. However, as Roger Smith (1991) suggests, 'Probably only since the 1950s is it really legitimate to refer to forensic psychiatry as a distinct occupation'. But before describing the evolutionary process from the mid-20th century onwards, it is important to go back and examine the contribution of other pioneers, far less publicised and indeed far less distinguished in medical terms than Conolly, Forbes Winslow, Maudsley, or the Monros – the gaol or prison doctors. Conditions in English gaols in the 18th century were appalling. Typhus fever, 'gaol fever' was rampant. Those suffering from mental disorders were thrown in indiscriminantly with other wretches to suffer the same squalor. John Howard (c1726-90), the far-famed philanthropist, was so horrified by what he saw when, as High Sheriff of Bedfordshire, he inspected Bedford gaol, that he immediately began to campaign for improvements. His report, *The State of the Prisons*, published in 1777, led to the Act of 1779 and, most importantly, to the provision of something approaching a Prison Medical Service. The Act required local justices to appoint a physician and a chaplain to each of the 200 prisons which existed at that time. As a result, inmates were kept under closer supervision and those considered to be suffering from mental disorder were authorised by the Secretary of State to be transferred to county asylums, which had begun to proliferate as the 19th century progressed.

In 1864, mentally ill convicts, who had accumulated in Dartmoor, were transferred to Millbank and in 1861, Bethlem Hospital opened a separate

criminal lunatics wing, to be followed by the opening of Broadmoor Asylum, as it was then named, in 1863.

Towards the end of the 19th century, part-time civilian physicians were appointed to prisons who, together with the permanent medical officers, formed the nucleus of the Prison Medical Service as we know it today.

The concept that in the case of mentally abnormal offenders, treatment rather than punishment was more appropriate was mooted only as recently as 1919, and the prime mover in this respect was Dr. M. Hamblin-Smith (1922), the medical officer at Birmingham Prison. As a direct result of this initiative, Dr. W. H. Hubert of St. Thomas' Hospital, London, was appointed the first 'visiting psychotherapist' to Wormwood Scrubs Prison. He, together with Sir Hubert East, published a report in 1939, *The Psychological Treatment of Crime*, which was to be a bench-mark in the development of psychiatric facilities for prisoners. Unfortunately, the East-Hubert recommendations that a psychiatric prison be built had to be postponed because of World War II, and it was not until 1962 that Grendon Underwood was opened under the directorship of Dr. W. J. Gray.

Today, the Prison Medical Service is administered by the Home Office Prison Department and offers a reasonably comprehensive service by medical officers who are either full- or part-time, the latter usually being local G.Ps. There is a growing awareness of the importance of psychiatry by the Prison Department and as a consequence, something approaching 50% of medical officers hold a psychiatric qualification. Medical officers today provide reports when required by the courts, or these may be volunteered if they are considered appropriate. However, in the case of mentally ill prisoners, the assistance of consultants in the NHS is sought in preparing reports. The Home Office may also appoint Forensic Consultants, drawn from suitably qualified and experienced psychiatrists in the NHS, whose job it is to prepare court reports on all cases where the prisoner stands charged with a capital offence. If the court, usually a Crown Court, sees fit it may call the same doctor as an expert witness at the trial, to undergo examination or cross-examination and give an opinion on:

- (1) the accused's fitness to plead
- (2) his or her fitness to stand trial
- (3) whether, at the time of the killing, the accused was suffering from such abnormality of mind arising from arrested or retarded development of mind, as substantially impaired his mental responsibility for his acts so that the requirements to substantiate a plea of diminished responsibility (Section 2 (i) Homicide Act, 1957) could be met
- (4) if such a plea is accepted whether the accused should be disposed of under the due process of law, or under the Mental Health Act, 1983.

It is standing in the witness box that the psychiatrist is most vulnerable: it is then that, if there is to be an adversarial struggle between prosecution and defence, he or she can become the target for aggressive cross-examination by counsel 'for the other side'.

The Contribution of Criminology to Forensic Psychiatry

Criminology, the scientific study of non-legal aspects of crime, including its

causes and prevention, achieved academic respectability in England comparatively recently. Its introduction here from Europe was in fact due in large measure to the unspeakable Nazi persecution which led to distinguished authorities in Germany, such as Max Grünhut and Herman Mannheim, finding refuge in England, as did Leon (later Sir Leon) Radzinowitz, an emigré from Poland.

Grünhut established himself in Oxford, where he was eventually made Reader in Criminology. His work, in which he was ably assisted by Sarah McCabe, is of particular importance to forensic psychiatrists in that his last book, *Probation & Mental Treatment* (1963) is the first to examine in detail the consequences of legislation designed to deal with mentally abnormal offenders.

Mannheim, formerly Professor of Criminal Law and Procedure in the University of Berlin, settled in 1934 in England, where he established criminology as an independent subject of University teaching. He taught, inter alia, at London University, at the Institute for the Study & Treatment of Delinquency, London, and most importantly, at the Maudsley Hospital. He was a prolific writer: his two-volume textbook of *Comparative Criminology* (1965) is a classic and required reading for students of criminology and forensic psychiatry.

Sir Leon Radzinowitz, a man of international repute, is best known in this country in association with the Institute of Criminology at Cambridge, of which he was director, holding at the same time the Wolfson Chair in Criminology in the University from 1960-72. The Institute, the most important of its kind in the UK, is internationally recognised and attracts students not only of criminology but of forensic psychiatry and sociology, including those seconded from the Probation Service and the Home Office Prisons Department. The Institute holds seminars on topics of interdisciplinary importance. Sir Leon was succeeded as director and professor by Nigel Walker, the most distinguished home-grown criminologist in Britain. Before his translation to Cambridge, Walker had succeeded Grünhut as Reader in Criminology at Oxford.

Walker, a polymath, is the author of many books, all written, as befits a classicist, with clarity and with a scintillating donnish wit. Of particular interest to psychiatrists is his *A Short History of Psychotherapy* (1957); but his two volume *Crime & Insanity in England* (1968 and 1973) is his *magnum opus*, as important to forensic psychiatrists as it is to criminologists. His importance as a link-man between the two disciplines, criminology and psychiatry, has been recognised by his election to the Honorary Fellowship of the Royal College of Psychiatrists.

It is noteworthy, as further evidence of the cross-fertilisation between the same two disciplines, that Walker was in turn succeeded at the Cambridge Institute of Criminology by Professor Donald West, a distinguished psychiatrist and a product of the Forensic Unit at the Maudsley Hospital; he too, has a long string of important contributions to the literature to his credit mainly concerned with the prediction of delinquency in children.

Emmanuel Miller as an early pioneer forensic psychiatrist

Although forensic psychiatry as a select and cohesive discipline began to take final shape in the 1950s, there were individuals and institutions who made indirect, but nevertheless vital contributions to the evolutionary process in

the preceding decades. Of particular note in this context is Dr. Emmanuel Miller who, in 1927, established the first Child Guidance Clinic in London's East End. Miller's work became known to W. Clarke-Hall, stipendiary magistrate of the important Old Street Court, London, EC1, who was so impressed that he invited Miller to sit with him, especially when young offenders were before the Bench. Clarke-Hall initiated the procedure whereby a youngster could be put on probation with the condition that he attend Dr. Miller's clinic for treatment.

Coincidentally, The Mental Treatment Act, 1930, played its part. This Act – the first concerned with the mentally ill to include 'Treatment' in its title – allowed the mentally ill to be admitted voluntarily to approved hospitals. About this time, psychotherapeutic clinics began to make their appearances such as the West End Hospital for Nervous Diseases, to become known later as the Portman Clinic. Taking a leaf out of Clarke-Hall's book, magistrates, notably Claud Mullins, began the practice of using probation orders as a means of ensuring in-patient or out-patient psychiatric treatment for adult offenders.

Forensic Psychiatry Comes of Age

If the Cambridge Institute of Criminology was the *fons et origo* and now the power-house for the study of criminology in England, the same may be said for the Institute of Psychiatry in London in respect of forensic psychiatry. The founding father, academically speaking at least, was T.C.N. Gibbens (1913-83), who served as Senior Lecturer from 1950-67 before being promoted Professor of Forensic Psychiatry in 1967, a position he held until he retired in 1978.

Gibbens' academic distinction was such that his services were sought by a multitude of prestigious national and international committees and profession bodies. These included the Streatfield Committee (1958), The Royal Commission on Penal Reform (1964-66), The Heilbron Committee (1975), and the Policy Advisory Committee to the Criminal Law Revision Committee (1976-79). He was President of the British Academy of Forensic Sciences (1967-68), Chairman of the Institute for the Study & Treatment of Delinquency (1974-81), Vice-Chairman of the Howard League (1971) as well as serving on the Parole Board (1972-75). Apart from these extra-curricular activities, he had to find time for teaching and for the clinical demands made on him as Consultant Psychiatrist to the Bethlem Royal and Maudsley Hospitals as well as to the London Remand Home for Girls.

Peter Scott (1914-77) was an almost exact contemporary of Trevor Gibbens and must share pride of place with him in the Pantheon of British forensic psychiatrists. Of the esteem in which he was held by his own colleagues and those working in the wider context of the social sciences, it is appropriate to quote Baroness Wootton. In her Maudsley Lecture, given in 1979, she spoke feelingly of 'our much beloved Peter Scott whose premature death has left a gap which many of us feel can never be filled'.

Scott and Gibbens complemented each other: Gibbens was much more the academic, whereas Scott was more in evidence as an expert witness in the Crown Court in trials of major offenders. He was one of the first, in fact, to take up a joint appointment between the NHS and the Prison Medical Service, in his case, as Consultant to the Bethlem and Maudsley Hospitals and

Brixton Prison, to the latter half of which appointment I succeeded after his tragic death.

Nevertheless, Scott found time to serve on a variety of important committees and to advise the police on how to handle extremely difficult siege situations such as the Spaghetti House and Balcombe Street sieges. In addition, he proved a tower of strength to the Royal College of Psychiatrists after its establishment in 1971, particularly in relation to forensic matters; in 1973, he prepared a report on battered wives at the request of the Department of Health & Social Security. In 1976 he was elected chairman of the College's Forensic Section and was responsible for the submission to the Criminal Law Revision Committee on Sexual Offenders. Again, in the same year, he prepared material for the College's contribution to the Home Office Working Party on Judicial Training and Information and chaired another committee which submitted evidence to a select committee considering non-accidental injury to children. As further evidence of the crossover between criminology and forensic psychiatry, it should be noted that Scott served as one of the editors of the *British Journal of Criminology*.

The reputation of the Maudsley as a centre of excellence in the development of forensic psychiatry and as a school for trainees has been fully maintained by John Gunn who succeeded Trevor Gibbens as professor in 1978. The Department now boasts, in addition to Professor Gunn, a Professor of Special Hospital Psychiatry (Pamela Taylor), a Reader in Forensic Psychology, five Senior Lecturers, an Honorary Senior Lecturer, eight Lecturers, an Honorary Lecturer, and eight research workers – in all a very sizeable team. The Maudsley can now offer as evidence of its pre-eminence in the field its claim to have colonised with its alumni a handsome proportion of the centres where forensic psychiatry is practised.

Development and training in forensic psychiatry is not, however, confined to London and it behoves any historian to pay tribute to Professor Robert Buglass who has elevated his department in the University of Birmingham to a position of first-rate national and international importance.

The development of forensic psychiatry amongst the generality of psychiatrists was previously handicapped by the lack of a suitable forum, but this lack was made good by the establishment within the Royal College of Psychiatrists, founded in 1971, of a Section of Forensic Psychiatry. This boasts a large membership and holds regular meetings, including an annual residential conference spread over three days, offering an ambitious programme with an international panel of speakers.

The absence hitherto of a corpus of specialised publications has been very adequately filled recently by two excellent text-books on forensic psychiatry – *Principles and Practice of Forensic Psychiatry* published in 1990, and edited by Robert Buglass and Paul Bowden; and *Forensic Psychiatry, Clinical, Legal and Ethical Issues*, published in 1993 and edited by John Gunn and Pamela Taylor. There are now two journals, both emanating from the Maudsley. The first, *The Journal of Forensic Psychiatry*, is edited by Paul Bowden and is published three times a year; it has an editorial board of international experts and publishes papers written by authors from the world over. The second, *Criminal Behaviour and Mental Health*, edited by John Gunn, Pamela Taylor, and David Farrington is published quarterly and is of comparable distinction.

In detailing the reasons for the promotion of forensic psychiatry from a position below the salt to one at the academic High Table, it would be less than just not to mention the important catalytic role of the Parole Board.

Since its inception in 1967, almost all senior forensic psychiatrists have served on the Parole Board. Apart from the responsible nature of the work itself, the opportunity is presented to psychiatrists to sharpen their wits on the whetstone of some of the finest legal brains in the country in an atmosphere of informality. What is more, the debates are conducted without rancour and with due regard to the weight of each other's argument. The net result is a feeling of respect, one for the other.

Epilogue

It is indisputable that since the 18th century, when the 'mad doctors' first began to make their appearance in the courts of law with any frequency, forensic psychiatry has taken giant steps forward and that this is particularly so since the 1950s, when the science first achieved academic respectability. But has this respectability been reflected in an improved relationship between psychiatrists and jurists in the conduct of trials in courts of law? There has certainly been an improvement but, if there is to be a clash, it comes about almost invariably in trials for murder, particularly where a plea of diminished responsibility has been raised under Section 2(1) of the Homicide Act, 1957.

In the light of the serious inconsistencies which have been exposed in such trials, is it not time to take a long look at alternatives, and in particular at the recommendations of the Report of the Committee on Mentally Abnormal Offenders (The Butler Report, 1975)? Their most important recommendation in this context was that the mandatory life sentence for murder be abolished, so that the need for verdicts of diminished responsibility would be done away with. The wisdom of such a tactic would be that killers would have the opportunity to plead guilty to murder and allow any psychiatric evidence to be presented to the Courts as mitigating circumstances at the sentencing stage. The Court would then be entitled to award a less severe sentence or make a hospital order under the Mental Health Act, 1983, or any subsequent Act.

It is well known that such a move finds favour in the eyes of a number of lawyers, and would most certainly commend itself to the vast majority of forensic psychiatrists, who as things are, are weary of the Olympian arrogance and bullyboy methods of cross-examination of some leading counsel in trials for murder.

As for the public at large, it may well be that there has been more progress on the road to liberality than is generally believed. As witness this belief, it is possible to cite the calm public reaction to the exemplary judicial handling of the trial of the infamous John Steed, the 'M4 rapist' and murderer. It is quite likely, indeed, that following the verdict in the McNaughton trial the jibes contained in the satirical verses published in the Times in 1843 have already lost their barb:-

Then Heigh to escape from the mad doctor's keys
Ant to pistol or stab whomsoever they please, etc

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I take great pleasure in acknowledging my debt to Professors Nigel Walker, John Gunn and Robert Bluglass for the help given to me in preparing this chapter. As always I am deeply indebted to Mrs. Diana Shields for her customary efficiency in deciphering my appalling handwriting and preparing an immaculate manuscript.

14 Irish Psychiatry in the Twentieth Century

DAVID HEALY

In 1894, the Medico-Psychological Association met in Ireland for the fourth time, under the presidency of Dr Connolly Norman, then the medical superintendent of the largest psychiatric hospital in the country – the Richmond Asylum (later Grangegorman Mental Hospital). This was 33 years after the first meeting of the MPA in Ireland under Norman's predecessor, James Lalor, whose stewardship of the same Asylum had been enlightened in its emphasis on psychosocial aspects of the care of patients (Lalor, 1861; Healy, 1991; Browne & Healy, 1992; Reynolds, 1992).

Norman was also progressive. His presidential address made some of the earliest comments on the dangers of institutionalisation (Norman, 1894; Webb, 1990). He drew attention to less custodial regimes then being practised in Belgium and Germany (see also Norman 1895, 1903, 1904a,b). He bemoaned the fact that the sheer size of the asylum, along with a lack of medical support, meant that he and other Irish colleagues were unable to find the time to engage in research.

Yet despite awareness of these problems at the highest levels, the size of Grangegorman almost doubled during the subsequent 70 years – a period during which the population of Ireland, uniquely in Europe, declined substantially. By 1961, between its central facility and auxilliary establishments, the hospital had over 4000 patients. Despite the only professorial unit in the country being located there, this state of affairs clearly militated against care, teaching and research. In 1961, psychiatric bed usage, in the Republic of Ireland, was the highest in the world, possibly the highest ever recorded anywhere, standing at 7.3 per 1,000 (Commission, 1966). One in 70 people above the age of 24 was in a psychiatric hospital bed. In some parts of the west of Ireland, the figure was up to 11.0 beds per 1,000 (Browne, 1985). This compared with figures of 4.6 per 1,000 in the United Kingdom, 4.3 in the United States and 3.5 in France (Commission, 1966)

In the sense that the occupancy of hospital beds by patients with mental disorders rose in other countries between the years 1890 and 1950, Ireland was not unique. But in the case of Ireland, which began the century as a poor country, the questions must arise as to why such a costly burden was incurred by the state, relative to other countries, why the shift to community care, that began elsewhere as early as 1945/1946, was delayed by 20 years, and why until very recently there

was very little research into the origins or determinants of high bed usage. There had been commissions to look at the issues involved in mental illness in Ireland in 1804, 1817, 1841, 1856, 1878, and 1890, while Ireland was part of the United Kingdom but there was nothing further until 1961, apart from a commission, in 1925, to consider the relief of the sick and destitute poor, whose brief included the insane poor (Commission 1966). Why?

The historical period can be conveniently divided in three. The first was from 1894 when the emergence of a peculiarly Irish problem was first recognised to 1929 when the Censorship of Publications Act was passed. The second was from 1929 to 1961, when the Commission for mental illness began its work and a third period runs from 1961 to the present day. I will focus on a conference of resident medical superintendents held in 1903, at the Richmond Asylum, to consider the apparent increase in insanity in Ireland, and on the controversy stirred up by the Free State's efforts to set up a health service, in the middle years of the century. The thesis that will be developed is that the processes leading to and stemming from Irish liberation lent a distinctive character to services in Ireland for the mentally ill and that they did so in great part through an interaction with Catholic social thinking of the time.

From 1894 to 1929

Between 1847 and 1899, uniquely compared to other countries in Europe, there was a fall in the population of Ireland from 8,175,124 to 4,576,181, owing to deaths from the Great Famine and to the emigration it set in train (Foster, 1985). In the face of this, however, there was a rise in registered lunatics from 6,180 to 20,304 (Jones, 1904a). To most hospital superintendents and governors, the rise appeared to be increasing in pace during the period 1895 to 1903, causing considerable alarm at both the implications to the social fabric and the tax burden.

The prevailing view in the early years of the century was that there actually was a genuinely higher incidence of mental illness in Ireland compared with that in other countries. This view emerged early and was a subject for discussion at meetings of the Medico-Psychological Association as early as 1894 (Drapes, 1894; Tuke, 1894). With the development of the dementia praecox concept (criticised by Norman, 1904c), and later the schizophrenia concept, the view emerged that Ireland had more schizophrenics than elsewhere – a view that was seemingly confirmed by studies during the 1960s and 1970s (Walsh, 1968, 1969, 1971, 1972; Walsh & Walsh, 1968).

More recently, with the advent of historiographical interest in the question of the provision of services for the mentally ill in Ireland (Finnane, 1981; Robins, 1986), an alternative explanation has begun to emerge. According to a 'popular' version of this latter view, the provision of asylum beds in Ireland reflected a policy of containment, such as was applied nowhere else in the world. However, there is no evidence in favour of any deliberate or overt policy of containment.

An asylum building programme began in earnest in Ireland during the 1820s (Finnane, 1981). Even before the Famine, there were criticisms that more beds than were needed were being provided (Finnane, 1981). However, despite an initial generous provision of asylum beds, the halving of the population by the

Famine and the further provision of asylum beds thereafter, by the 1870s the asylums were so seriously overcrowded that there were complaints that conditions were deteriorating (Eames, 1885; Finnane, 1981).

One influence on the scale of the building programme may have been that English rulers in Ireland were able to treat some aspects of public policy as a matter of experiment – the ‘English habit of treating Ireland as a society whose good was to be pursued by English statesmen acting on their own initiative and in their own light’ (Hammond, 1964). In many areas of social welfare, such as the Foundling Hospitals, Charter Schools, Houses of Industry and the institutions of the Poor Law, provisions in Ireland were niggardly and apparently predicated on a desire to proselytise and thereby conquer (Robins, 1980), but the record where mental health was concerned was better. The first hospital for criminal lunatics in these islands was established in Dublin. The early asylum building programme was undertaken in response to the claims of the moral treatment movement which favoured such a provision. Where the later asylums were concerned, however, less care appears to have been taken in their building and in the recruitment of staff, and it has been claimed that the fabric of the buildings and morale of the institutions was inferior to that elsewhere in the United Kingdom (Robins, 1980).

Conference of the Irish Asylums Committee – 1903

There was therefore a generous provision of asylum beds in Ireland at the start of the period. Nevertheless, the overcrowding consequent on an apparent rise in rates of hospitalisation for lunacy led to the convening of a Conference of the Irish Asylums Committee, at the Richmond Hospital in Nov. 1903 (Conference, 1904). This was attended by lay and medical representatives from most of the asylums in the country. It was a two day meeting, at which a range of views on the causes of the increase were aired, with particular discussions on the role of heredity, intemperance and conflict. There were also proposals for the management of the problem, regarding which the delegates broadly speaking divided into two camps – those who favoured building more asylums and those who favoured community care.

It was felt that one of the usual reasons given for increased rates of mental illness elsewhere – a high incidence of syphilis – couldn’t apply, given that Ireland was Catholic (Drapes, 1904a; see also Drapes, 1894). However, paradoxically, the reduced incidence of syphilis and GPI was proposed as a factor leading to an increase in the hospital population, by virtue of reduced death rates. This point is pertinent to the argument that will be developed in the discussion, in that the impressions of others subsequently have been that there was a substantial incidence of GPI in Ireland (Inspectors, 1906; Browne & Healy, 1992).

A: Heredity

On the question of why the number of asylum inmates was increasing so dramatically, there was general consensus among all speakers that, in part, the increase stemmed from a transfer of demented and mentally handicapped

subjects from workhouses to the asylums (Drapes, 1904a). Given that there was a continuing increase in the rate of first admissions, however, and that this rate considerably exceeded that reported for England, it was felt that the reported figures represented an absolute increase in the prevalence of mental illness per head of the population (O'Neill, 1904; Graham, 1904; Drapes, 1904a). What was less certain, however, was whether that increase was partly brought about by a high rate of emigration of the able-bodied, leaving a disproportionate number of the mentally vulnerable behind (Clancy, 1904), augmented by the deportation back from the United States of emigrants who developed psychiatric disorders there.

Either way, great concern was expressed at the numbers of the insane who were accumulating, as it was felt were these individuals to marry and breed, the incidence of mental illness must increase further in future generations (Drapes, 1904a; Carre, 1904a; Lawless, 1904; Woods, 1904a; O'Neill, 1904; Jones, 1904b). The temper of this debate contrasts with one held following the Presidential Address to an MPA meeting in Ireland in 1875, when similar fears of a rising incidence of insanity were raised (Duncan, 1875). Then, it was argued that the increasing complexity of modern civilisation was leading to degeneracy – a view fashionable for the time (Pick, 1991; Healy, 1993).

The belief, that those affected by mental illness should not be allowed to beget children, influenced the course of discussion on the second day of the meeting, when alternatives to the central asylum were reviewed (Drapes, 1904b; Carre, 1904b; Woods, 1904b; Nolan, 1904). Two options were considered – a system of boarding out and the establishment of auxiliary asylums. Those in favour of the latter option argued that preventing the discharge of the mentally ill to the community would lessen the risk of misbegotten children (Carre 1904b; Woods 1904b).

Such concerns led to a number of meetings aimed at the establishment of eugenics societies in Ireland in the period 1911-1915 (Jones, 1992). None flourished, however. Of note to the argument being developed is that, in the face these serious problems, in which he accepted that heredity might play a part, the Bishop of Ross, Dr Kelly (Kelly, 1904a), a delegate to the Conference and a notable player in Irish mental health politics, indicated the probable opposition of the Church to the kind of measures that the eugenicists were likely to put forward (and later did advocate).

The issue of intemperance was related to the question of heredity. According to statistics put forward by Drapes (1904a) and in the opinion of almost all speakers (Woods, 1904a; O'Neill, 1904), intemperance was associated with insanity, although there was some dispute as to the causal relationship between the two (Graham, 1904; Davidson, 1904). It was argued that this was another good reason to opt for a system of auxiliary asylums rather than community care.

B: Conflict & Mental Illness

In contrast, to the period before 1880, in the 20-year period to 1902, it was claimed that there was a marked reduction in the reported occurrence of insanity as a consequence of poverty and adversity (-35 %), religion (-31.5%), domestic trouble (-41%) and mental anxiety (-62.3%), with a corresponding rise

in the number of cases put down to heredity (Drapes 1904a). This suggested a change from an established tradition, first put forward by Halloran in 1818, which believed that social turmoil and political troubles could give rise to mental illness.

However, even as the conference was being held, the first psychi-atric casualties of the Boer War were taking places in Irish asylums. However, unlike the position elsewhere in the United Kingdom, the Imperial exchequer did not grant any extra funding to Irish asylums to pay for the care of those who had lost their wits in the service of the Empire (Clay, 1904; O'Kane, 1904). The issue of conflict-associated mental disturbances came to a head with World War I. This gave rise to substantial numbers of psychiatric casualties - so substantial that the problem was only manageable by the setting up of outpatient services (Stone 1985). Given that there were proportionately at least as many Irishmen enrolled in the war effort as Englishmen (McRedmond 1991), there must have been comparable problems in Ireland in the aftermath of the war.

There were, however, two differences between Ireland and the rest of the United Kingdom, which militated against a recognition of conflict-induced mental illness. One was that returning soldiers did not return as heroes; following the Irish Rebellion in 1916, the political situation had changed completely. A second difference lay in the programme for reconstruction put in place after the war, to look after the housing, health and other needs of the demobilised soldiery. On the mainland, this was generous but most probably owing to the uncertainty of the political situation, aside from patchy attempts to monitor for VD and TB, the provisions of this programme were never extended to Ireland (Barrington, 1987).

Added to the traumas of the Great War, there was the Irish Revolution, stretching from the Rising in 1916 to the Black & Tan War and then the Civil War in 1922. There is at least anecdotal evidence that these conflagrations contributed to the in-patient population in the absence of any other available services (Malcolm, 1989).

C: Asylum Building versus Community Care

If it is conceded that the primary motive for the provision of so many asylum beds was unlikely to be simply one of containment, there remains the fact that the availability of so many beds at a time of great social dislocation must inevitably have had social consequences.

In the first instance, this assisted the 'warehousing' of women and children during and immediately after the Great Famine of 1845-1847 (Robins, 1980). Subsequently, with the departure through emigration of many of the most able-bodied and an agricultural depression during the 1890's, the remaining populace must have had great difficulties in caring for the elderly, the demented and the mentally handicapped in their communities. There is a perception that after the famine, these drifted into the workhouses and were decanted from there, during the 1890s, to the asylums (Robins 1980; Reynolds 1992). As well as filling the asylums, this admixture of patients can also have been expected to lead to a deskilling of staff, a loss of morale and increasing pessimism regarding

the prospects for cure, all of which were notable in the Richmond Asylum from the 1890s (Reynolds 1992).

Some observers believed that available asylum beds were also used for the purpose of 'wintering in' in certain parts of the country (Browne & Healy, 1992). Delegates to the 1903 conference reported that relatives would obtain the discharge of patients during the summer months and put them to work on the farm, only to get them readmitted during the winter (Mills, 1904).

In 1891, the Mitchell commission met to consider the question of proper provision for lunatics. They recommended that district boards of lunacy should replace the then existing district lunatic asylum boards and that the new boards should have responsibility for the care and treatment of lunatics, whether in asylums, other establishments or in the community. In contrast, the function of the lunatic asylum boards was solely to operate the asylums. Any attempt on the part of the asylum boards to deviate from their legal authority by admitting voluntary patients, establishing out-patient clinics or providing for care in the community was rejected on the grounds of *ultra vires*.

The Mitchell commission's recommendations were not adopted and indeed a new Local Government (Ireland) Act in 1898 reinforced the dominance of the law and further blinkered the views of both central government and the asylum boards. (It was not until a Health Authorities Act in 1960 that mental hospital boards were dissolved and health authorities were made responsible for all health care, including mental health care. Even then the power of custom and tradition militated against change).

One of the opponents of the Mitchell commission's recommendations was the Bishop of Ross, Dr Kelly, who was a prominent participant at the 1903 meeting. His solution to the issue of appropriate provision for the mentally ill was the provision of auxiliary asylums for harmless chronic lunatics. These would be staffed in part by nuns, who would work for considerably less money than other attendants, and who would be overseen by visiting physicians rather than resident medical superintendents (Kelly, 1904b). However these suggestions came to nought owing to recommendations of the MPA (Harvey, 1904) which had been worked out 40 years previously and accepted by government following a piece of astute lobbying by both English and Irish members of the Association (Healy, 1991). His views on auxiliary asylums, however, prevailed and his presence on a Royal Commission to look at health care, which reported in 1909 led to a recommendation that underused workhouse buildings could be converted for this purpose (Finnane, 1981). As early as 1904, when the first such facilities were being established, it was predicted that they would quickly become seen as a sentence to incurability and as such would lead to even more demoralisation than obtained already within the existing asylums (Harvey, 1904).

The asylum building programme, and the later conversion of workhouses to hospitals, was one of the larger building programmes carried out in Ireland before independence. In many rural areas in particular, the asylums also appear to have been a notable source of employment, as well as significant consumers of local produce, etc (Finnane, 1981; Robins, 1986). Factors, such as these, contributed, as late as 1985, to vigorous local opposition to the proposed closure of a number of fairly dilapidated asylums (Robins, 1986), it is perhaps not surprising, therefore, that there was resistance at the 1903 meeting to any proposed rundown, however modest, through

schemes such as one put forward by Norman to board out patients (Norman, 1904a).

Mental Health Legislation & Medicine

A further factor was that no matter how progressive Irish medical superintendents were, they had no control over the admission of patients. In 1867, the existing mental health legislation in Ireland was amended to permit magistrates to commit 'dangerous' lunatics directly to asylums. There was an immediate increase in the rate of admissions and committal by this means consistently accounted for over 50% of all committals thereafter (Finnane, 1981). Inspectors and medical superintendents protested that when magistrates were bound to commit dangerous lunatics to jail they made careful enquiries in order to avoid wrongful committal but when the law was changed they no longer made such enquiries, the simple fact of insanity in any degree being sufficient to justify committal (Psychological Retrospect, 1875; Norman, 1886).

Ireland diverged increasingly from the rest of the UK thereafter. The various revision of mental health legislation in 1890, 1930 etc in Britain did not happen in Ireland, where the provisions of the 1867 Act remained in force until 1945. Irish patients moreover, until the establishment of the Free State, were liable to be escorted to hospital by armed policemen.

Politics & Medicine

It has been argued that while conditions in the asylums during the 1890s and early years of the 20th century were recognised to be poor, little political movement on this question was possible. This was because any attempt to address the issues of either the causes of the apparent excess of mental illness in Ireland or the management of the problem was all too likely to interface with the politics of Home Rule (Finnane, 1981). With the imminence of Home Rule, Irish politicians were concerned about any arrangements that might increase the financial problems with which they would have to grapple in the event of any devolution of sovereignty (Barrington, 1987). English politicians, in turn, were wary of any trade-off on Home Rule they might have to make in return for Irish support for social reforms.

This dynamic was exposed most clearly in 1911 with the tabling by the Liberal Government of a Health Insurance Bill, which aimed at widespread health cover through an insurance system underwritten by the State and linked to a system of benefits to cover sanatorium care and medical certification for sickness, disability or maternity (Barrington, 1987). The Irish Party at Westminster could not be seen to support a 'British' bill too keenly, but at the same time, they were dependent on the Liberals for the introduction of Home Rule, and so went along with it, subject to amendments for Ireland. This ambivalence of the politicians was exploited by parts of the Irish medical profession and by the Catholic Hierarchy. Those doctors engaged in private practice and consultants to the voluntary hospitals, which were run by religious orders, opposed the Act on the grounds that it would be professionally demeaning to be contracted for



Dr Peter Duncan Scott, FRCP, FRCPsych, CBE
(Photograph courtesy of the Royal College of Physicians [chap. 13].)



Dr Trevor Charles Noel Gibbens, FRCP, FRCPsych, CBE
(Photograph courtesy of the Royal College of Physicians [chap. 13].)



Thomas Chivers Graves as the Duke of Plaza Toro, from a hospital Gilbert and Sullivan production [chap 25]. (Photograph courtesy of Mr. Frederick Graves.)



Thomas Chivers Graves on the occasion of his election to the Presidency of the RMPA [chap 25]. (Photograph courtesy of *Journal of Mental Science*.)

services on a capitation basis and that it would also reduce the demand for private practice (Barrington, 1987).

The Church also opposed the Bill on the basis that it would in effect involve additional taxation, which would not be sustainable (Barrington, 1987). Apart from comment on educational matters during the 19th century, this issue marked a first intervention of the Catholic Church in the politics of social welfare in Ireland. It also marked the establishment of an alliance between elements within Irish medicine and the Catholic Church – an alliance that was to dictate the future evolution of health services in Ireland.

In failing to endorse the National Insurance proposal wholeheartedly, so that its main provisions never applied to Ireland, the Irish Party lost an opportunity to do away with a despised Poor Law system and missed an opportunity to create a proper health system. In the process, Ireland rejected what was later to be a major foundation of the British Welfare State.

Subsequent independence posed a further political problem, unique to mental health. Even prior to independence, the Royal Colleges of Physicians & Surgeons in Ireland were independent of their British counterparts, but where the MPA was concerned, Irish psychiatrists remained members of the British body even after 1922. It has been argued that the Irish members of the MPA were skillful in using the example of conditions elsewhere in the Union and the support of colleagues from the British mainland to further their professional and political goals in the second half of the 19th century (Healy, 1991). This avenue was not open to them after independence. Appeals to examples in the UK, at least temporarily, could not be expected to have quite the same weight with a native administration, as they might with Lord Lieutenants who were spending time in Ireland with a view to furthering a career on the mainland.

From 1929 to 1961

Far from independence bringing signs of possible decarceration for the mentally ill, their numbers kept rising in the face of an ever diminishing population. This increase, in great part, must be attributed to the structural legacy of mental health legislation and lunatic asylum boards left in place after the British departure. The mystery of this second period of Irish history is why little or nothing was done about these problems before the 1960s. Two reasons for this will be considered.

The continued increase in admissions led the worried governors of Grangegorman Mental Hospital (Richmond Asylum) to seek a Commission of Enquiry from the government (Coyle et al, 1934; Reynolds, 1992). They were rebuffed. The relevant minister, who was the minister for Local Government (as Ireland still did not have a Department of Health), advised them to educate the public and to establish outpatient departments (Coyle et al, 1934). The first psychiatric outpatient clinic was indeed established in 1935 but this was coincidental - the initiative came from the private sector (Eustace and Healy, 1995).

There was no further government consideration of mental illness until the passage of the 1945 Mental Treatment Act, which was tabled without significant consultation with any interested parties (Eustace and Healy, 1995). This act replaced the 1867 provisions. It permitted voluntary admissions to public

hospitals for the first time and introduced temporary certification. Discharge however even for voluntary patients was at the discretion of the medical superintendent, who could temporarily certify the patient if he was unhappy with the discharge. The fact that all discharges had to be funnelled through one individual militated against de-institutionalisation (Browne & Healy, 1992). This was changed in 1962 but it remains the case that the consultant in charge of a patient must consent to their discharge. This and a number of other anomalies have recently led to considerable public concern about the operation of the 1945 Act (Dail, 1992).

The refusal to consider appointing a commission was justified on the grounds that 'the causation of mental disorder and mental defect had for several generations [already] engaged the attentions of numerous investigators in almost every land, and [this] had resulted in a wealth of scientific knowledge which afforded a basis on which the public organisation of facilities for the prevention, care and treatment, of mental abnormality could be based'. This was almost certainly a rationalisation for an unwillingness to spend money as there was a concomitant refusal to provide pathology services in the asylums, even though these were thought necessary in Britain and Europe. There were also, as we shall see, considerable obstacles in the way of 'education' of the public.

The economic problems that the new state faced were formidable. Emigration on a large scale provided the most important safety valve for a set of difficult social problems. Unbelievable though it may seem, it may also have been convenient to sequester single people, especially women. Large numbers of men and women, in Ireland during this period, had to remain celibate and single given that the majority of the population were tied to the land and the rules of inheritance dictated that farms were passed on to eldest sons. This frequently resulted in younger sons and consequently an equivalent number of single women not being able to marry as they would not have the wherewithal to maintain themselves (Whyte, 1980; Lee 1989). While emigration provided a safety valve for men, women were less likely to have this escape route. From the early years of the century, the number of women exceeded those of men in Irish asylums and a large proportion of these were single (Finnane, 1981). Did this have anything to do with inheritance? The fact that other issues to do with inheritance were clearly affected suggests it did. For example, a similar complex of social relations militated against adoption law reform (Whyte, 1980).

Gaelic and Catholic

Following Independence, it is not surprising that government priorities lay in areas other than the provision of services for the mentally ill. It was only towards 1930 that questions of social policy came to the fore in the Free State (Whyte, 1980). When they did so, the issues that emerged had obvious implications for the development of the psychiatric services.

In 1929, a Censorship of Publications Act was enacted. Authors banned under this act included Andre Gide, Jean-Paul Sartre, Ernest Hemmingway, John Steinbeck, Tennessee Williams and Grahame Greene. As studies of the Act indicate (Carlson, 1990), its effects were to produce something of a Captive Mind situation, quite comparable to that described by Czeslaw Milosz in Poland

after takeover by the communists (Milosz, 1979), with Catholic Realism replacing Socialist Realism in the order of things.

A variety of other provisions aimed at curbing drinking and controlling the supposedly immoral behaviour associated with dancing in dance halls. While there was a distinctly puritan streak to these new laws, it is important to note that they were aimed at curbing the pernicious effects of foreign influences rather than simply stamping out immorality (Whyte, 1980).

The significance of these acts is that the Free State was struggling to find an identity. It had been assumed that, once free, Ireland would be Gaelic and Catholic. But the Irish language, contrary to the expectations of the founders of the Free State, had gone into rapid decline, so that an important bulwark against non-Irish influences was simply not available. Indeed, the coincidence of the development of the wireless paradoxically led to the country being increasingly exposed to cultural imperialism from Britain. Arguably, the only available recourse was a retreat into Catholicism.

This retreat took place at a time when Catholicism worldwide appears to have felt threatened by socialism, communism and also by psychoanalysis and behaviourism. This added to the difficulties of generating a properly Irish and Catholic culture and gave rise to something of a siege mentality (Whyte, 1980; Lee, 1989). A central thesis of this chapter is the proposal that this development led to a situation in which Catholic disapproval of doctrines such as psychoanalysis or behaviourism, which had minimal impact elsewhere, had significant and dramatic effects in Ireland.

The Mother and Child Controversy

The 'socialist threat' led to the articulation of a socioeconomic ideology, which has been termed vocationalism (Whyte, 1980). This stood in opposition to, what was seen by many Catholics, as the centralising and bureaucratic tendencies of socialism and communism. Vocationalism advocated self-regulating professions and crafts. Its adherents were opposed to state involvement in general, seeing in this the creation of conditions that might later lead on to socialism.

Vocationalist critics argued that foreign health services were not 'noted for their Christian spirit, as they were materialist in their conception and merely palliative in their results' (Dignan, 1945). A hazard of the vocationalist approach was that it risked being high-jacked by the political interests of some of the vocations that were supposed to spear-head Christian thinking in their respective areas. In the case of medicine, it is notable that private practice was seen as something of a Christian virtue. The development of vocationalism led in due course to a celebrated clash between church and state, which was one of the defining moments of Irish political life in the twentieth century. This is popularly known as the Mother & Child controversy.

In 1947, a white paper was published aimed at establishing a nationalised health service, with restrictions on eligibility, which were to be lifted for maternity related health issues and the health of young children, including school children (Barrington, 1987). The Fianna Fail government fell before the bill could pass and were succeeded by an Inter-Party government, whose minister of health was Dr Noel Browne. He reactivated the Fianna Fail Health Bill with some

modifications, one of which was ultimately to provide a free for all service. This was opposed by the Irish Medical Association. It was also opposed by the Catholic hierarchy on the grounds that it was the duty, right and privilege of parents to provide these services and taking away the element of struggle in their provision was thought to be morally and socially inappropriate (Whyte, 1980).

The new bill also sought to make provisions for the education of mothers in matters related to childbirth and the rearing of children. This was a sensitive issue for the Catholic Church, which was committed to maintaining a comprehensive hold on the educational system in Ireland (Whyte, 1980). The state provided the funds to build schools and pay for teachers' salaries, but the Church ran the schools and determined the curricula. It reacted with extraordinary sensitivity to any measures which might infringe on its dominating position in the educational system (Whyte, 1980) and proposals to educate mothers appeared to do just this.

A further aspect of the proposed health provisions were that post-natal and school inspections of children would be compulsory. The tenor of the debate on this issue, clearly reflects a failure to appreciate the changing nature of health services (Whyte, 1980; Barrington, 1987). Those against the provisions saw health in terms of voluntary attendance at local general practitioners' surgeries, rather than something that should be the subject of public health provisions and proper epidemiological surveys. One of the hierarchy's complaints was that the scheme regarded illness as a matter for public record and research, without regard to the individuals' right to privacy (Staunton, 1950).

This controversy is of interest to any history of mental health in Ireland because of what it reveals of current thinking. In their submissions to the government, concerning the involvement of the state in the educational system, the hierarchy did not stress their concern about losing control of the educational system *per se*, but rather a concern about the kinds of information that might be imparted by obstetricians, gynaecologists and psychiatrists in intimate personal areas:

'It is precisely in this sphere of health education, where so many moral questions arise, that conflicts with totalitarian regimes have developed elsewhere' (Hierarchy, 1947). 'Health education often involves the claim to direct the child according to pernicious Freudian and materialist principles' (D'Alton et al, 1953). 'The bill contains no safeguard that patients will not be obliged to accept treatment in obstetrics, gynaecology and psychiatry from men who are imbued with materialistic principles or advocate practices contrary to the natural law' (D'Alton et al, 1953).

In the case of psychiatry, the Catholic Church worldwide was hostile to materialist reductionist doctrines including psychoanalysis, behaviourist psychology and dynamic psychologies in general – the work of Janet and James for instance (Healy, 1993). A worldwide proscription on hypnosis was only lifted in 1955. In Ireland, where devotional piety was perhaps more marked than anywhere else in Europe at the time (Brown, 1987), there was an obvious threat from work that suggested that stigmata could be produced by hysterical mechanisms and that mystical ecstasy was just one of many altered states of consciousness (Healy 1993).

This hostility must inevitably have put a brake on any attempts to modernise the psychiatric services, in particular in Ireland where vocationalism rose to a position of orthodoxy. There appears to have been no great market for the

works of Freud or Jung in Ireland during this period (McGrath & Healy, 1992; Moore & Healy, 1993). While none of the works of the depth psychologists appears to have been formally banned, the climate of the times was such that the obvious disapproval of the Church for this line of thinking and the association of analytic ideas with sex and other banned subjects would have led to a voluntary suspension of sales of these works (Carlson, 1990). There was an effective proscription on any psychiatrist becoming an analyst (McGrath & Healy, 1992). This proscription had been circumvented in countries such as the United States, but not so in Ireland.

Something of a breakthrough on these issues came with a book entitled *The Priest and Mental Health* (O'Doherty & McGrath, 1962), which proceeded from a series of seminars organised by Drs O'Doherty and McGrath during the late 1950s. This book appears uncontroversial now but was something of a pathbreaker at the time. While it was undoubtedly radical in the Irish context, the need for a volume such as this appears to have been felt widely in Catholic circles, so much so that it sold extensively in the United States also (McGrath, Personal Comm).

Church attitudes to psychoanalysis had softened in Ireland by the 1960s, in great part owing to the influence of Fehin O'Doherty, who was later Professor of Psychology in University College Dublin (UCD/Catholic). A marked hostility to behaviourism, however, remained until the mid 1970s. Students seeking advice on a career in psychology as late as 1973 were liable to be informed by Dr O'Doherty that the behaviourist approach, as embodied in the Trinity College (Protestant) psychology course, produced a pagan and materialistic psychology. In contrast, while flirting with the depth psychologies, the UCD psychology course remained centred on metaphysics until well into the 1970s.

From 1961 to 1991

By 1960, the scale of the mental illness problem was beginning to be appreciated (Lyons, 1971). This led to the establishment of a Commission on Mental Illness, which commenced in 1961 and brought out its recommendations in 1966. Since then, the changes that have been brought about have been comprehensive. Can we explain why this happened?

There were a number of factors intrinsic to psychiatry. It would have been impossible to ignore the changes which had been taking place in the United Kingdom and elsewhere for almost two decades. A number of apparently small changes, such as making it possible for psychiatrists other than the medical superintendent to authorise discharge probably also contributed. The effective advent of outpatient psychiatry, which although first established in 1935 only really took root in the latter half of the 1950s, coincident with the introduction of the new psychotropic drugs (Malcolm, 1989; Moore & Healy, 1993) must also have been important. Finally, the creation of district general hospital units, the first of which was set up in Waterford (Lynch & Healy, 1993) aided in destigmatising mental illness.

Outside psychiatry, however, there were also changes taking place in Irish culture. Starting around 1958, there was a palpable change in Irish life (Lyons, 1971; Whyte, 1980; Lee, 1989). Where before the mood of the nation had been

one of gloom and despair, there appeared to be a distinct shift towards a more optimistic and energetically involved frame of mind. A number of parties cite the publication in 1958 of a Programme for Economic Development as either the trigger for the change or one of its defining moments. This programme led to a spell of economic growth that exceeded any that had been obtained previously, such that during the 1960s and 1970s, there was a reversal of the net emigration of population that had been such a feature of Irish life for the previous century.

Concurrent with these changes, there were developments within the Catholic Church also. This was a period during which the Second Vatican Council took place, which suggested that much that was formerly considered timeless and immutable should be regarded as relative and subject to evolution. In 1972, the special status of the Church, which had been guaranteed in the 1937 constitution, was dropped by public referendum. There was at the same time a shift of generation in the hierarchy; a number of prominent older members died and a new cohort came to prominence. Far from offering further resistance to the encroachment of the State, a number of these latter felt that the only problem with State intervention in Ireland was that there was not enough (Whyte, 1980; Lee, 1989). Many prominent members of the hierarchy became associated with support for socialist causes.

A further factor, which may have had a disproportionate influence in Ireland, was the election of a catholic to the presidency of the United States. Kennedy's election and visit to Ireland provided a potent symbol of what people might aspire to. From 1960 through to the late 1970s, his picture was commonly to be found hanging over Irish fireplaces beside that of the Pope of the day. His death and subsequent fall from grace, and the specific nature of that fall brought to a focus many of the tensions inherent in the Catholic worldview of the times.

From 1960, there seems to have been a general shift in Irish thinking away from ideology and mythology and toward a interest in collecting empirical data and establishing the exact nature of affairs rather than the wished-for nature of those affairs. The establishment of the Commission on Mental Illness in 1961 was but one instance of this process. It was followed by reports of the Commission of Enquiry on Mental Handicap (1965), of an Interdepartmental Committee on the Care of the Aged (1968), of the Interdepartmental Committee on Mentally Ill and Maladjusted Persons (1978) and on Services for the Mentally Handicapped (1980). Bodies such as the Economic & Social Research Institute and the Medico-Social Research Board (1965) were established to provide data for processes of evaluation and change.

During the 1960s and 1970s, professorial chairs in sociology, politics and related disciplines were established. Chairs of psychiatry were also established, leading to a generational change at the top of the psychiatric profession, with an associated openness to new ideas. The process of deinstitutionalisation began in earnest during the latter half of the 1960s, which culminated in 1984 in a blueprint for the development of a community mental health service (Dept, 1984). At the time of writing, community provisions in Ireland would appear to be at least as good as those in the United Kingdom (Lynch & Healy, 1993).

One result of more systematic teaching and research has been a questioning of the diagnosis of schizophrenia, which along with a change in the availability of psychiatric beds in accordance with mental health planning (Walsh, 1987) has led to a recognition that Ireland has no higher a prevalence rate of schizophrenia

than elsewhere (Walsh et al, 1980; NiNuallain et al, 1987; 1990). Similarly, there has been a questioning of the incidence of suicide. For many years, it was believed that the rate in Ireland was extremely low – of the order of 3.0 per 100,000 compared with 11.0 in the U.K., for example. The conventional explanation was that this was because Ireland was a Catholic country. However, a number of studies have led to a revision of estimates such that it is now uncertain whether Irish rates differ much if at all from those in Britain (McCarthy & Walsh, 1975; Clarke-Finnegan & Fahy, 1983; Walsh et al, 1990).

A Structural Legacy?

However, while previous circumscriptions on psycho-social investigation began to ease in the 1960s, one consequence of the siege mentality was a profusion of medical schools with the division of resources that this entails and this potentially will have ongoing effects on psychiatric practice and research.

As mentioned, the Catholic hierarchy have always reacted with extreme sensitivity on the issue of education. This sensitivity was first established during the 18th century, when Penal laws proscribed Catholic education. It was reinforced during the 19th century by clear evidence of attempted proselytisation on behalf of the established Church of students from foundling children (Robins, 1980) through to university students (Froggatt, 1991).

As regards the practice of psychiatry in Ireland, this sensitivity has had its principal effect at university level. In 1591, Trinity College had been founded as a Protestant university in Dublin. There has always been immense suspicion about Trinity on the part of the Catholic hierarchy, as is evidenced by the following citations.

Non-Catholic colleges, in as much as they are intrinsically dangerous to faith and morals, remain under the ban of the Church. Since there are within the Irish Free State three University Colleges sufficiently safe in regard to faith and morals, we, therefore, strictly inhibit, and under pain of grave sin we forbid priests and all clerics by advice or otherwise, to recommend parents or others who are in charge of youth to send the young persons in their charge to Trinity College. (Lenten Pastoral of Archbishop Byrne of Dublin 1930, cited in Whyte, 1980, p. 305)

No Catholic may enter the Protestant University of Trinity College without the previous permission of the Ordinary of the Diocese. Any Catholic who disobeys this law is guilty of mortal sin and while he persists in disobedience is unworthy to receive the sacraments. (Archbishop McQuaid of Dublin, 1945 cited in Whyte, 1980, p. 306)

Such sentiments led to the foundation of the National University of Ireland in 1908 (Fleetwood, 1983; Froggatt, 1991). This has meant there has been two university medical schools within the capital city. In addition, there has been a third medical school, located in the Royal College of Surgeons (Fleetwood, 1983; Lynch & Healy, 1993). Furthermore, there was also a great deal of internal politics regarding the establishment of professorial departments of psychiatry between the universities and their associated teaching hospitals, which being

voluntary hospitals are effectively autonomous. In the case of University College Dublin alone, this led to there being three chairs of psychiatry (Browne & Healy, 1992) – but no senior lecturers. In Trinity, it led to two chairs, one in the University proper and one in St Patrick's Hospital (Moore & Healy, 1993; Malcolm, 1989). There was a further chair in the College of Surgeons'.

Thus there have been six chairs of psychiatry within the same city but, in contrast, only two properly constituted senior lecturer posts. This has meant that there has been no department of psychiatry geared towards the conduct of research. The departments have essentially aimed at training medical students. The need for a research focus has been keenly felt and this has led to proposals on various occasions to establish a research institute (Daly, 1990; Hartman, 1990; Clare et al, 1990). One effect of this lack of a central research structure has meant that those most interested in psychiatric research have tended to emigrate.

The Catholic hierarchy's opposition to Trinity was dropped in 1970 but this came too late to prevent the above developments. A government attempt to merge University College Dublin and Trinity College, despite interest in and appreciation of the rationality of the proposal, came to naught, owing to the rival identities and investments of both institutions (Whyte, 1980). The problems, however, for higher postgraduate education as a consequence of the multiplicity of chairs and teaching hospitals, as well as the interplay between private and public arms of the service, have, in contrast, been overcome by the creation of a unified postgraduate training committee (McGrath & Healy, 1992; Lynch & Healy, 1993; Browne & Healy, 1992).

Discussion

Can we say then, what factors have primarily determined Irish psychiatric bed usage during the period under review? In 1961, the group of countries that had the next greatest recourse to psychiatric bed usage were the countries of the United Kingdom. While bed usage in England, Scotland and Northern Ireland was only some two-thirds that of Ireland, it seems reasonable to suggest that the determinants of bed usage in Ireland must have been in part the same as those that determined usage in the rest of the British Isles.

Among the factors which favoured an institutional answer to the problems of mental illness in Ireland was a caution regarding insanity and the risks it posed to the wider population (Browne & Healy 1992). This problem was aggravated by the fact that Irish medical superintendents often spent 30 or more years in post. Thus in the case of Grangegorman only 5 individuals occupied the post between 1857 and 1994. In the case of John Dunne, the superintendent between 1937 and 1966, the workload involved overseeing the care of 4,000 inpatients, conducting several outpatient clinics in the public service and running a busy private practice. It can be seen, therefore, that the system was always liable to 'default' towards oversight and continued inpatient care.

In addition, Irish asylums suffered from a chronic admixture of mentally handicapped patients with general adult patients, elderly demented individuals, alcoholics, vagrants, and other public nuisances (Reynolds, 1992). The administrative changes that brought about a separation of such groups and a fostering of the specific skills necessary for the proper management of each of them, that

occurred in the 1950s in the UK and US, were slow in coming to Ireland. It was effectively the late 1960s before the institutional culture changed.

But in addition to Irish variation on common factors, there must be additional factors to account for the excess of beds used in Ireland. One such factor must be a hitherto unaccounted for Irish love-affair with hospital beds. Ireland not only had the highest rates of psychiatric bed usage in the world, it also had the highest rates of general bed usage (Commission, 1966).

Furthermore, in contrast to the UK, Ireland maintained a mixture of private and public health services, throughout the period. This, along with emigration, probably reduced the pressure for change within the public system, in that those who were likely to be the most vocal advocates of change were less likely to be exposed to conditions that they might have protested about.

Account must also be taken of the constant drain on social networks caused by emigration and the dismal failure of the country to perform well economically. Emigration has been doubly disabling, by virtue of the trauma caused to those left behind but also because of the loss of networks to support those who become ill. Studies by Rawnsley and colleagues, in the 1960s, of the Rhondda Valley in Wales, which also experienced significant emigration, indicate that for whatever specific reasons, large-scale emigration appears to lead to increased hospitalisation for psychiatric disorders in the population that remains behind (Ingham et al, 1972).

The combined weight of these factors might suggest that Ireland provides a textbook example in support of Richard Warner's arguments regarding the interplay between the chronicity of mental illness and political economies (Warner 1985). However, the interest in Irish psychiatric bed usage does not lie simply in the numbers of patients involved and some relationship between those numbers and the adversity of economic circumstances but rather in the peculiarities hidden within the figures – the lack of suicides and syphilitics and the excess of schizophrenics suggesting that in addition to the specific class factors identified by Warner, there were a set of other factors deserving of further exploration.

The Myth of Irish Mental Illness

The primary thesis of this chapter is that there was a specific interaction between the mental health services and Irish Catholicism that has contributed to the peculiarities of Irish psychiatric bed usage in the 20th century.

What must be borne in mind is that the Free State was in a very vulnerable position at the time of independence: its distinctive Celtic language had been lost, its institutions and bureaucracy were taken lock, stock and barrel from Britain and there was a need to assert an identity, in contrast to Northern Ireland, which shared the island but remained a part of the United Kingdom. In addition, economic performance was abject: emigration, on a massive scale, was perhaps the single reason the ship of state kept floating (Lee, 1989). Uniquely in Europe, the population of Ireland in 1990 is somewhat less than it was in 1870 – which in turn was greatly reduced compared to 1845 – in the face of one of the highest birth rates in Europe (Lee, 1989).

Conditions such as these must inevitably affect the morale of a nation. They

can be expected to encourage a tribal and mythic response, and in Ireland in the twentieth century, Catholicism was the most convenient and coherent ethos around which to organise such a response. Myths can be either heuristic or defensive. A number of commentators have recently argued that the notion of a 'Gaelic and Catholic' Ireland was clearly defensive in nature (Foster, 1976; Lee, 1989).

In favour of such a proposal, there is a great deal of evidence that the Irish State and people paid attention to their Catholic clergy on matters of sexual and social morals, but not on issues of nationalism. Repeatedly, through the 19th century and from the 1916 rising through to the civil war and the IRA campaigns in the 1950s and 1970s, the people of the South have paid little heed to proscriptions of violence – even when these have been accompanied by threats of excommunication (Whyte, 1980).

However, it would be a mistake to think that there was a straightforward antagonism between the church and psychiatry. In other parts of Europe, the Church did not have the same inhibitory effect on the development of psychiatric thinking or services. And indeed in Ireland, the influence of the church cannot simply be interpreted as purely inhibitory. A number of religious orders involved themselves in mental health. The most notable of these were the Saint John of God brothers, who established a voluntary hospital for nervous disorders in Dublin in 1885. This was expanded in 1955 and it grew, thereafter, to become a centre of innovative care in the country (McGrath & Healy, 1992). The St John of God brothers were also heavily involved in the establishment of child psychiatric services in the country. Other orders, such as the Brothers of Charity, have played a central part in the development of services for the mentally handicapped.

Furthermore, the testimony of individuals such as Professor Norman Moore, the medical director of St Patrick's Hospital from 1946 through to 1977, is that there was little if any interference from the Church. In practice, by the 1950s, many Catholic patients were encouraged, even by members of the clergy, to go to the Protestant St Patrick's Hospital for treatment of their nervous disorders (Moore & Healy, 1993).

How can evidence such as this be reconciled with an argument that the church applied a brake to development? One possibility is that the nature of Catholic influence on Irish life during this period was complex rather than unitary. If, for example, Catholicism functioned as a badge of tribal identity, the turn to a particularly fervent form of Catholicism, after independence, can be seen as a defensive reaction against which even the Church itself may have had to struggle – or perhaps should have struggled. If this were the case, then one might expect that what were minor difficulties with twentieth century ideologies in other Catholic countries would be major obstacles to twentieth century forms of development in Ireland, with the evidence that this was the case lying in the lack of appropriate developments.

The circumstances surrounding the development and adoption of the 1937 constitution merit consideration here. The original 1922 constitution was non-denominational and non-discriminatory and there was no popular agitation for a change of constitution. A referendum to adopt a new constitution, which created a republic and gave the Catholic Church an established role in Irish life, coincided with a general election in 1937, which the governing party, Fianna Fail, had looked like losing (Lee, 1989). Playing the constitutional card,

a nationalist and Catholic card, was a clearly political move. Given that De Valera and his Fianna Fail party had been prepared to accept excommunication by the Church, for their part in opposing with arms the acceptance of partition and the creation of the Free State, such a gesture suggests a political move to forge a national identity. This idea is supported by any consideration of the themes from speeches De Valera gave and measures he adopted, during this period of extreme economic and political adversity, which were aimed at promoting the vision of a Catholic Ireland, self-reliant and self-sufficient (Lyons, 1971; Lee, 1989).

This use of a 'Catholic Ireland myth' was only possible by virtue of the course of national development in the 15 years following independence. Its use, in turn, set the seal on the creation of something close to a de facto confessional state. This state of mind appears to have interacted most clearly (and to some extent remains likely to interact) with social issues where the nature of the Irish stereotype is called into question. The misleading figures on suicide, outlined above, which is not something that 'Irish Catholics' do, clearly indicate this.

A further example can be drawn from attitudes to syphilis. The occurrence of syphilis in Ireland, as we have seen, was dismissed in 1894 and again in 1903 because of *a priori* assumptions about Ireland being not only a Catholic country but devoutly so. This attitude persisted through to the late 1980's, when it became impossible to ignore what had become a substantial incidence of AIDS in Ireland, allied to which has been the realisation that Ireland has developed a drug abuse problem equal to any other European country, with an associated level of crime.

The question of abortion has most recently come to public attention, and is another instance of the operation of the same effect. Abortion is something that clearly should not happen in a 'properly' Catholic country and a legal service for abortion has never been provided in Ireland. This has led to an exporting of the problem to the United Kingdom (Whyte, 1980). In 1983, an amendment to the Irish constitution, aimed at preserving the right to life of the unborn child, was adopted in the belief that it proscribed abortion under any circumstances. The meaning of this particular constitutional provision was tested in the case of a 14-year old girl who was depressed and suicidal after becoming pregnant. In the debate, that ensued following a ruling that it was permissible for her to seek an abortion in the U.K., it has become clear that many of those who are anti-abortion appear to be relatively happy to export the problem of abortions (Holden, 1994). This view appears to mean something to the effect that provided what is happening is not happening on Irish soil, it can be tolerated. While there is a diversity of opinion as to the appropriate solution to the problems, there is some consensus that the emotions raised indicate that this debate has touched on questions of national identity rather than just matters of social morality.

A further feature illustrated by the abortion controversies, which have run for over a decade now, is how 'catholic' the medical profession in Ireland remains, in the sense of rigidly adhering to moral orthodoxies as put forward by the catholic hierarchy, than the rest of the population (Kennedy, 1993).

Where the above issues are concerned the interaction between tribal myth and social problems has led to a denial of the existence of certain problems. It can be expected, however, that if a myth is in operation, there will be ways in which it may lead to a over-recognition rather than a denial of problems. The

question of the apparently high frequency of schizophrenia in Ireland might be explained in this way. In the lexicon of Gaelic and Catholic mythology, Ireland has traditionally been known as an island of saints and scholars. Picking up on this point, Nancy Scheper-Hughes (1979), suggested that it was an island of saints, scholars and schizophrenics – that the conditions that were conducive to the production of clerical vocations and scholarly aptitude were the same conditions that produced schizophrenia.

There is a long tradition behind the argument that great wits are to madness near allied (Claridge et al, 1990). It may well have seemed to many that the incidence of schizophrenia in Ireland was an inevitable counterpart of the number and sanctity of its clerics. As such it would not be something in need of urgent investigation and remedy; indeed it might be something not to be too closely investigated for fear that the solution of one problem might create another.

Whatever, the merits of Sheper-Hughes' arguments, the public responses to them have been instructive in their own right. In general, her book has been seen as anti-Irish, anti-Catholic and anti-clerical (Callagan, 1979; Nowland, 1979; Kane, 1979; Viney, 1980; Scheper-Hughes, 1981; Viney, 1983; Scheper-Hughes 1983). Despite winning awards for the anthropological quality of the work and despite reaching a 20th edition in the U.S., and despite being one of the few books to tackle specifically the issue of mental illness in Ireland, *The Island of Saints, Scholars and Schizophrenics* sold poorly in Ireland and has been unavailable for most of the time since its publication.

There is a further possibility that needs consideration. It seems increasingly clear in recent years that trauma during childhood, whether sexual abuse, physical violence or emotional cruelty, can lead to explosive and borderline personality disorders, which when allied with transient psychoses, often give a schizophreniform picture, which would have been all but certain to lead to a diagnosis of schizophrenia until recently (Healy, 1993). When the writing of this chapter began, Irish bookshops have stocked and Irish newspapers have carried detailed stories of serious child abuse (Doyle 1988; Maher 1993). Whether the incidence of such abuse is greater than anywhere else is a matter for which there is at present no good evidence. As the writing of this chapter drew to a close, the Irish government fell, in part owing to circumstances surrounding the activities of a paedophile priest and the role of both Church and State in overlooking such activities when there has been clerical involvement.

The Evidence from Irish Literature

Given that until 1966 there were no official examinations of Irish mental illness or the services to deal with this problem, there is a need to turn to other sources of evidence. Since national literatures can be a source of considerable information, what does Irish literature reveal?

Remarkably, almost nothing – except perhaps in so far as that nothing is in itself significant. Given, the highest psychiatric bed usage in world and accordingly what must have been a regular series of dramas played out in the mental health arena, one might expect some reflection of this in the national literature. This is doubly surprising because in addition to apparently

producing more lunatics, during this period Ireland also produced more writers of genius per head of the population than any other country in the Western world. Not only this, but Irish writers were distinctive in their psychological sophistication and modernity. Yeats elaborated a psychology of consciousness that was quite comparable to Jung's. Joyce introduced the notion of a stream of consciousness, that was consistent with the work of Janet and other psychologists of consciousness. Wilde and Shaw analysed the effects of capitalism and Empire on national and social identity, while Beckett articulated archetypes of modern alienation. A range of other authors including Kavanagh, O'Connor, Lavin, Behan and O'Brien have analysed in telling detail the effects of Catholic and peasant mentalities on individual identity. The flow of genius appears endless with moderns such as Heaney, Friel, Trevor and Doyle replacing those who have gone before.

But nowhere do any of these authors deal with the issues of mental illness. Madness is used as a literary device in Yeats' Crazy Jane poems, and psychoanalysis is referred to ironically in Frank O'Connor's *My Oedipus Complex*. But – aside from oblique reference to the Irish way of handling mental illness in Kate O'Brien's *The Ante Room* (1941), a book which was banned in Ireland, and William Trevor's *Reading Turgenev* (1989), the closest any Irish author gets to the reality of mental illness or the incarceration of the insane was Samuel Beckett, who almost accidentally, it would seem, describes Malone looking down on Portrane asylum in a manner that suggests Beckett had little empathy for or comprehension of the reality of mental illness.

This seems remarkable and it stands in marked contrast to the role Flaubert's Madame Bovary played in stimulating French psychiatric thinking in the later half of the 19th century (Micale, 1993). In Britain, mental illness played a prominent role in the work or lives of Shakespeare, Johnson, Clare, Smart, Cowper, Woolf, Browning, Lamb and the Brontes. Elsewhere in English-speaking literature or cinema, madness has played a part in the work of Dickinson, Frame, Kesey, Allen and Beers, among many others. In German-speaking countries, furthermore, there has been the overwhelming influence of the 'literary' works of Freud and Jung.

Concluding Remarks

One could argue that the trauma of national liberation would inevitably take a considerable period of time to work through before resulting in a population that was more confident in its identity and encouraged to take on the necessary tasks of national development. The chain of events outlined above does, in some respects, seem to fit such a picture.

Of particular relevance to psychiatry has been the interaction between this process and the almost exclusive turn to Catholic social positions that this involved, which affected the development of psychiatric thinking and practice in Ireland through the proscription of eugenics and both depth psychology and behaviourism. This influence can certainly not be seen as all regressive – the role of religious orders in the care for the mentally ill and the testimony of many psychiatrists during the period argues against this. It also interacted clearly with other factors such as the split between public and private provision of health

care and emigration. Having said this, the influence of the Catholic Church does seem to have acted like a weight in the dice in a manner comparable to the way divisions between the Protestant Churches in England affected the development of psychiatric thinking and practice there during the 17th and 18th century (MacDonald 1981).

The matter seems in many respects to have been aptly put by Brendan Behan when he said 'Other nations have a history, the Jews and the Irish have a psychosis'. Of interest here is the contrast between the Jewish handling of mental illness issues, which has involved an immersion in matters to do with mental illness that has led to Jews being at the forefront of the development of both dynamic psychiatry and psychopharmacology and Irish denial, the full history of which remains to be told.

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15 'Where lunatics abound': A history of mental health services in Northern Ireland

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The title for this chapter is taken from a letter written by William Todd, Secretary of the Asylum Commission in the early nineteenth century, who wrote: 'lunatics abound more in Ulster than any other part of Ireland' [PRO(Irl), 1819]. Yet before 1825, when Armagh District Asylum was built, there were no public facilities for the insane in Ulster, Ireland's most northerly province. Provision consisted of two rooms in the Belfast Charitable Society, Cliften House, and the private madhouse of Henry Reid at Downpatrick (Mc Clelland, 1988; Parkinson, 1969). Pauper lunatics were either in prison or 'wandering at large', while those with money sought treatment in Swift's St Patrick's Hospital in Dublin (HMSO, 1817 : Malcolm, 1989, p. 93). By the end of the century, there were 16,500 beds in public asylums in Ireland with 3,300 of them in Ulster (Finnane, 1981, p. 227). As we now approach the end of the next century, there is a new pattern of care and treatment; with fewer beds and greater community-based provision. It is therefore no longer sufficient to give bed numbers as a measure of services. However, the psychiatric hospitalisation rate for the Republic of Ireland is still high by international standards (Moran & Walsh, 1991, p. 12), while that for Northern Ireland, though higher than in England & Wales, is lower than in the rest of Ireland. Use of mental health services in Northern Ireland remain different from other areas of the United Kingdom despite the fact that health policies have almost converged over the past 70 years. In this chapter it is argued that both patterns of service development and legal changes are not only steeped in the historical roots of nineteenth-century Irish lunacy policies, but also have been shaped by the peculiarities of government which have characterised the Northern Ireland state since its creation in 1921. The result is a psychiatric service which, though it has echoes in Ireland and in England, remains different from both.

The early twentieth century

In 1921, when Northern Ireland came into existence, mental health provision consisted of six district asylums - at Armagh, Antrim, Belfast, Derry, Omagh, and Downpatrick, as well as one private asylum (the Retreat at Armagh) and a small number of private nursing homes catering for single certified lunatics. The

workhouse system, already in decline, offered limited care to people suffering from senile dementia and mental handicap, while criminals 'found insane' by the courts had been sent to the Central Criminal Lunatic Asylum at Dundrum, Dublin (established in 1845). There were a number of problems inherent in this system of provision, most of which derived from the lack of interest by the government of the United Kingdom in the question of lunacy during the last quarter of the nineteenth century. Unlike England, there had been no lunacy reform movement in Ireland. This was due largely to two factors: the preoccupation of the population at large with the question of political independence and the predominance of paupers among confined lunatics. As a result, the patients in institutions were forgotten by all except those involved in their care or in financing that care.

The first district asylums in Ireland were built to cater for 100 to 150 patients. For example, Armagh (1825), Derry (1829) and Belfast (1829) had 104 beds in each. The second wave of asylum building, however, spurred on by Dr Francis White, the first Inspector of Lunatics, produced larger institutions. Consequently, Omagh (1853) and Downpatrick (1869) had 300 beds each and Antrim (1899), the last asylum built in Ireland, had 400. By 1921, all asylums were much bigger, with Belfast housing almost 1,000 patients and Omagh and Downpatrick with over 700 in each [HMSO(NI), 1924]. This expansion has been attributed by Raftery (1985, p. 287) to changes in the method of funding the asylum system in 1875, from one financed entirely from local taxation to one partly supported by a centrally funded per-capita grant. However, though this was a significant factor in encouraging existing asylums to increase their bed numbers, it must be taken in the context of the thrust by the powerful Lunacy Inspectorate to build new asylums in the second half of the nineteenth century. Furthermore, the expansion also reflected increased demand for admission which was due mainly to changing farming practices, emigration, and a decline in marriage (Finnane, 1981, p. 136).

Unfortunately, this growth in numbers of patients was not matched by enlightened legislation, nor by advances in medical treatment. The era of greatest development in treatment of insanity was over by then. In the early part of the century, moral management, based on the work of Samuel Tuke of the York Retreat, was held in high regard due mainly to the work of Thomas Jackson (Manager at Armagh Asylum from 1925) and Thomas Cumming (Manager at Belfast Asylum from 1829). Optimism about the efficacy of medical treatment was at its height in the middle of the century, when Dr Robert Stuart was acclaimed both nationally and internationally as a leading authority on the treatment of lunatics (Griffiths 1994; Mc Clelland 1988). Stuart, a graduate of Glasgow University and a student of Robert Cleghorn, Professor of Medicine and Chemistry, was highly respected for his skill in combining moral management with medical treatment. He was the first Resident Medical Officer in Ireland (appointed in 1835) and he placed Belfast Asylum at the forefront of care and treatment for mental disorder during his early years as manager. Towards the end of the century, there is little evidence in either the medical or general press that any of the small number of doctors involved in management and treatment within asylums were powerful members of their profession or had any international recognition. This was in spite of the fact that a revision of the Privy Council Rules in 1862 confirmed the position of doctors as experts in lunacy

TABLE 1

*The legal basis for admission to asylums before 1932**Admission as a person of unsound mind*

Local Government (Ireland) Act 1898. Sect. 9(6) [61 & 62 Vict. c. 37]

Admission as a dangerous lunatic

Lunacy (Ireland) Act 1867. Sect. 10 [30 & 31 Vict. c. 118]

Admission as a criminal lunatic

By order of the Governor of Northern Ireland

Army Act 1881. Sect. 91

Naval Enlistment Act 1884. Sect. 3

Poor Law Act (Scotland) 1898. Sect. 6 [61 & 62 Vict. c. 21]

Lunatic Asylums (Ireland) Act 1875. Sect. 12 [38 & 39 Vict. c. 67]

Sources: Reports of Inspectors of Lunatics (NI) 1921-6; Mental Treatment Act (NI) 1932

management, by making it impossible for anyone other than a medically trained person to be appointed as manager (for discussion see Williamson, 1970).

By the 1920s, with large numbers of patients and inadequate resources, it was impossible for medical or nursing staff to provide anything more than basic physical care, yet an examination of case records for the period shows that some patients did benefit from asylum care. Admitted because of their bizarre or depressed behaviour, some improved without any medical intervention, having seen a doctor only once during their time in hospital. The main factor determining the discharge of these patients, appears to be the willingness of a family member to take them home (Downpatrick Asylum Casebooks, 1920-30). During the 1920s and 1930s, new treatment methods began to emerge. In the annual report of the Down Mental Hospital, Dr M. J. Nolan wrote: 'The keynote is hospitalisation, segregation of the mental classes, and suitable recreation and occupation to the widest possible extent' (Down, 1925, p. xiii). In the following year, he spoke of his delight at the fact that the three main elements of moral treatment 'discipline, order and employment' were in evidence in all wards, and during the early 1930s new buildings for 'electro-medical and hydro-therapeutic treatments', as well as for occupational therapy (or non-essential work) were opened (Parkinson, 1969, p. xvi). At the Belfast Asylum, malarial treatment for GPI (general paralysis of the insane) was introduced in 1924 by Professor York from the Liverpool Institute of Tropical Medicine [PRO(NI), HOS 28/1/1/14]. Other new treatments gaining popularity in Europe in the late 1930s, insulin therapy and electric therapy (ECT), came into use in the early 1940s.

Transforming the lunacy laws

For doctors and administrators working in asylums throughout Ireland during the early decades of the twentieth century, the law was a complicated web of at least ten different statutes (Prior, 1993, p. 25). The revision of the lunacy laws which occurred in England in 1890 did not extend to Ireland. Neither was the public outcry aroused in England by the committal of the wealthy Mrs Weldon (Jones, 1993, p. 107) echoed by a population worn down by poverty and political strife. The majority of people confined to Irish asylums were labelled as being both dangerous and poor and had little public sympathy. The following table summarises the law used in admissions during the 1920s.

The statutes did not include any precise definition of the type of mental

conditions regarded as 'lunacy', 'idiocy', 'insanity', or 'unsoundness of mind', but it was generally accepted that there was a distinction between medical and legal definitions. Abraham (1886), in his major treatise on *Laws & Practice of Lunacy in Ireland*, described the legal position as follows:

The jurist views the condition of mind called lunacy or insanity with an exclusive eye to its effect upon the doings of the lunatic . . . Considered in his capacity of citizen, the person alleged to be of unsound mind may, through absence or disorder of intellect, create the belief among his friends and neighbours that he ought to be placed under tutelage, for safety of person and property, and it is to the judicial ascertainment of the truth on this particular that the common inquisition of office is directed. (Abraham, 1886, p. 13)

Judicial certification was seen in terms of protection for the person of unsound mind against possible exploitation, or for the safety of others. Medical certification, however, had a different function: it established that the mental disorder could be treated within a publicly funded institution (See HMSO, 1957, p. 46).

During the 1920s, the standard method of admission to district asylums was on the authority of a Reception Order, based on Section 9(6) of the Local Government (Irl) Act 1898. An application for the committal of a person alleged to be of 'unsound mind' was presented by the next of kin to the local resident magistrate or justice of the peace, who then sent it (with details of the person's residence and financial position) to the Registrar in Lunacy, who was the senior official (appointed by the Lord Chancellor) in the Lunacy Department at Dublin Castle. Having received this application, the Registrar sent a medical visitor to the person 'alleged to be of unsound mind', to examine him and to inform him of the application. The person examined had four days within which to lodge a written objection with the Registrar. The Registrar then sent the initial application, the report of the medical visitor, and any objections or evidence to the Lord Chief Justice, who made the decision 'to make an order' or to ask for a hearing of the case [HMSO(NI), 1930, p. 217; HMSO(Irl), 1904]. In this way, the law aimed to protect the liberty of the individual. However, the procedure was extremely unpopular, not only because of its cumbersome nature, but for two other reasons. If there was a problem with overcrowding in the asylum, patients admitted in this way could be redirected more easily to workhouses or back to relatives. Also, before 1901, this was the only category of patient for whom relatives were obliged to pay maintenance. If possible, therefore, relatives tried to have a patient admitted as a 'dangerous lunatic', to avoid any further financial responsibility (for discussion see Finnane, 1981, Ch. 3).

Surprisingly, changes in the law, when they did come, were not initiated from within Northern Ireland. Rather, the impetus came from developments in England, where a Royal Commission on Lunacy & Mental Disorder was appointed in 1924. The report of the Commission emphasised the need to break the link between the Poor Law and asylum treatment, and the importance of reducing barriers to treatment for mental disorders (Macmillan Report, 1926). Most of the recommendations of the Commission found legal expression in the Mental Treatment Act 1930 (for England & Wales) – a law which made the outmoded nature of the Northern Ireland legislation startlingly obvious. The process of change there did not take long, as local politicians were determined

to be seen as modern-minded, though some showed their lack of knowledge during the Second Reading of the Mental Treatment Bill (NI). John Beattie, for example, who was Labour MP for Pottinger, Belfast, regaled the Northern Ireland Parliament with stories aimed at convincing his listeners that no mentally ill person would seek treatment voluntarily, and that out-patient clinics would not work. He warned the Minister: 'If he thinks any person is going to go for extern treatment for mental disease, he is greatly mistaken' (NIHC Deb., 1932, Col. 562). However, in spite of views such as these, the new Mental Treatment Act (NI), which became law in 1932, made voluntary treatment and out-patient clinics a possibility. The Act was almost a copy of the English legislation, but though it was welcomed by professionals, it did not deal with the two main problems facing the service at the time. The first was the need for separate accommodation for patients with a mental handicap (none existed), and the second was the financial stress under which asylum management boards were operating, due to the freeze on central government funding since 1923 (Prior, 1993, pp. 43 & 51). Because of this, the new law made little difference to the experience of patients. However, the basis for change was now firmly in place and the ideological underpinnings of vagrancy and lunacy provision finally thrown aside.

After the war

Prior to the Second World War, the assumed temporary nature of the Northern Ireland state had been the main obstacle to policy decisions involving significant public expenditure, but events during the war caused a radical change in this situation. Northern Ireland proved itself a valuable asset to Britain, not only in practical terms (as a supplier of food, ships, and manpower) but also because of its strategic position. As a result, all plans for post-war reconstruction, including the introduction of a national health service, extended to Northern Ireland. This led to two major changes in mental health services. The first was the integration of the six large mental hospitals into a system of general health care under the auspices of the newly formed Northern Ireland Hospitals Authority (NIHA). The second was the passing of a new mental health law – the Mental Health Act (NI) 1948.

The inclusion of the former asylums in a hospital system guided predominantly by mainstream medical practice had repercussions not only on patients, but also on professionals. For the first time, staffing levels and qualifications, as well as treatment methods and equipment, were evaluated against standards prevalent in general medicine. Dr Duncan Leys, one of a three-man team funded by the Nuffield Foundation to carry out a Hospitals Survey in 1943, suggested that it was a 'physical impossibility for first class work to be done under such conditions' as those which prevailed in mental hospitals in Northern Ireland. He was highly critical of the fact that there were no laboratory technicians at mental hospitals, no psychiatric research workers, no attempt to treat neuroses, no psychiatric advice for schools and law courts, and only one psychiatric out-patient clinic [Regional Hospitals Council (NI), 1944, Sect. 53]. His criticisms though, touched only the tip of the iceberg: the truth was even more serious, as was clear in the first report of the Hospitals Authority. The mental hospitals, when transferred to

the Authority in 1948, were in a poor state of repair, outmoded in terms of basic sanitation and heating arrangements, overcrowded, uncomfortable, and lacking in basic medical amenities such as laboratories, Xray equipment, and operating theatres (NIHA Report 1949, pp. 51-9). However, a number of improvements were then planned as part of the overall development of hospital services in the Province [HMSO(NI), 1951, p. 57; NIHA Report, 1949, pp. 51-9]. Among them was the addition of 1,500 beds for mental illness and 1,000 for 'persons requiring special care' (mental handicap) [HMSO(NI), 1951, p. 75]. As a result of these plans and the injection of large sums of money by the Westminster government, mental health services developed in both quantity and quality during the following two decades.

Though criticised for being inefficient – a criticism which eventually led to a Parliamentary Enquiry (Tanner Report, 1955) – the Hospitals Authority very quickly improved the infrastructure of existing hospitals. By 1961, both Purdysburn and Downshire Hospitals had new Nurses Homes, a new administrative building and recreation hall were completed at Gransha, and extensive modernisation of patient accommodation had taken place at the Tyrone & Fermanagh and at Purdysburn Hospitals (NIHA Report, 1960, p. 65 and 1961, p. 69). The result was an improvement in living standards and of the quality of general medical care and treatment. During the 1950s, treatments such as ECT, insulin coma, and prefrontal leucotomy were in general use, although leucotomies were performed only at Purdysburn Hospital. By the 1960s, the treatment regime had again changed, due primarily to the availability of psychotropic drugs and to more critical scrutiny of earlier treatments; insulin therapy had been abandoned completely, and leucotomy strictly controlled [PRO(NI), HSS 16/3/125].

With improved access to treatment and an increase in hospital beds, came a steady growth in patient numbers. Psychiatric beds rose from 5,071 in 1948 to 6,486 in 1961, representing 3.8 per 1,000 of the population in 1948 and 4.5 per 1,000 in 1961. Although patient numbers began to decrease in 1961 (two years later than England), psychiatrists in the Province were slow to accept the service norms being planned for the United Kingdom. In an internal NIHA report on psychiatric services, a team of three consultant psychiatrists, led by J. Mulligan, suggested a norm of between 3.28 and 3.64 mental illness beds per 1,000 of the population (a reduction of one bed per 1,000 on the 1961 figure) and rejected the target proposed in the *Hospital Plan* of 1.8 per 1,000 (HMSO, 1962; Mulligan et al. 1964, pp. 5-7). A deep commitment to hospital-based treatment is clear in this and other reports of the period. Developments included the expansion of out-patient clinics during the 1950s [HMSO(NI) 1962, p. 10] and the opening of general hospital psychiatric units at the Belfast City Hospital (1960) and Ards Hospital (1961), and two Day Hospitals – at Cliften Street, Belfast (1961) and Albertbridge Road, Belfast (1963) (NIHA Reports, 1959-63).

The first hospital to explore the possibility of using community-based accommodation was the Downshire. As part of an effort to break down the barriers between patients and the world outside the hospital, a holiday centre at Tyrella Beach in Co Down was bought in 1954 (NIHA Report, 1957, p. 60); this holiday house represented an extension of the theme of occupational and diversional therapy for patients. The optimism of the time is clear in one description of the Tyrella project.

In order to encourage initiative and stimulate interest, attention has been concentrated on those projects offering hope of good development. Patients are being encouraged to do things for themselves and by themselves, consequently much of the work on the new holiday home at Tyrella and a great deal of work at the hospital has been carried out by the patients. . . . The hospital is pursuing the ideal of the therapeutic community, using occupational therapy not as a means of passing time, but as a way to individual development and as a means of contributing to community life and at the same time establishing more and stronger links with what used to be thought of as the outside world. (NIHA Report, 1957, p. 35)

The ideal of a 'therapeutic community' within a hospital setting, made popular by Maxwell Jones at Belmont and Dingleton (See Chapter 29), gave new enthusiasm to senior staff. For long-stay patients who had experienced the harshness of mental hospital life before the Second World War, these were happier times. However, as Kathleen Jones (1993, p. 152) reminds us, real community life lay outside these institutions and very soon the focus of care and treatment would change.

For psychiatrists and other mental health professionals, job opportunities and conditions of service improved dramatically after 1948. In 1960, the number of doctors working in mental hospitals was more than double that in 1948, nursing staff had increased by 58%, and Special Department staff (which included social workers and occupational therapists) by 450% (NIHA Report, 1960, p. 65). However, because of the small size of Northern Ireland, opportunities for specialised training were slow to develop, and in spite of 'generous secondment arrangements' by the Hospitals Authority, staff showed a great reluctance to take up training opportunities in Britain (NIHA Report, 1961, p. 69). Professional organisations lobbied for the establishment of academic training courses and research facilities in the Province, but it was not until the late 1950s that specialised training became a reality. In medicine, the turning point was the appointment in 1957 of John G. Gibson as the first Professor of Mental Health at Queen's University, Belfast. Training courses for psychiatric social work and occupational therapy were both in place by 1961, and nursing training (in spite of difficulties in recruiting female staff) was steadily brought into line with standards for general nursing qualifications [HMSO(NI), 1957, p. 28].

The Mental Health Acts of 1948 and 1961

After a century of piecemeal legislation in relation to mental disorder, Northern Ireland passed three Acts within a 30-year span, each attempting to make treatment more accessible, while protecting people from unnecessary or unlawful loss of liberty. Two of these, the Mental Treatment Act (NI) 1932 and the Mental Health Act (NI) 1961, resulted directly from changes in the law in England & Wales, but one, the Mental Health Act (NI) 1948, had no counterpart within the United Kingdom. The original intention was to make up for the lack of specific legislation on mental handicap, by introducing a law similar to the Mental Deficiency Acts of 1913 and 1927. However, the mental health services committee of the Health Advisory Council suggested a more radical approach.

We would suggest to the Minister, that the Act of 1932 and preceding Lunacy Acts, in so far as they are still current after the passing of the Health Services Bill, should be repealed by a Bill which would cover mental health, mental illness, and mental deficiency in all their aspects. [PRO(NI), HSS 16/4/79, Recommendation 5]

The advice of the committee was taken and after intensive debate and consultation, the new law came into force. Its main elements were (i) A new emphasis on the promotion of mental health rather than on the treatment of mental illness; (ii) The removal of judicial procedures (certification) from admission to mental hospital; (iii) The inclusion of mental illness and mental handicap in one Act; (iv) The establishment of a separate Special Care Service (mental handicap). The most controversial issue in the preparation for this legislation was the extent to which the judiciary should be involved in the admission and/or confinement of patients who did not voluntarily seek treatment. Though the 1932 Act had introduced the possibility of voluntary and temporary admission (which did not require judicial intervention), it was still possible to be certified as being 'of unsound mind'. A significant number of patients continued to be admitted by means of certification, though the proportion had decreased from 85% of total admissions in 1933 to 36% in 1948 [Weir, 1949; HMSO(NI), 1951]. The mental health services committee held the view that 'it was wrong for any patient to be admitted to a mental hospital as a certified patient with the accompanying stigma as such, where there was a reasonable prospect of recovery' [HMSO(NI), 1946, Sect. 6-7]. Certification, however, did not disappear from the legislation completely, but remained as a safeguard on the liberty of the long-stay patient. 'Where a temporary patient is judged by the Resident Medical Superintendent to have reached a stage where his recovery is improbable, he may apply to a "judicial authority" to have the patient certified' [Mental Health Act (NI) 1948, Sect. 9(1)]. The fact that involvement by the judiciary in hospital treatment remained on the statute books was due to the specific intervention of the Lord Chief Justice during the preparation of the Act. The position was made clear to the mental health services committee by the Legal Visitor in Lunacy, and was articulated by the Minister of Health & Local Government in a speech prepared (but not used) for the debate on the Bill in the Northern Ireland Parliament.

The Government is strenuously opposed to any suggestion that prolonged detention in a mental hospital should be authorised by any method other than by order of a judicial authority. The Lord Chief Justice is also opposed to it. It is submitted that mental illness must be treated differently from physical illness inasmuch as mental illness involves detention against the will of the patient and in some instances against the wishes of his friends or relatives. This means that the liberty of the subject is involved so that the problem is therefore more than a medical one and it is a fundamental principle of British justice that any such prolonged detention must be authorised only by a judicial authority. [PRO(NI) HSS 16/5/70]

The opposing argument was presented by D. B. M. Lothian, Medical Superintendent of the Downshire Hospital, and Vice-Chairman of the committee, who argued that existing safeguards were sufficient.

I understand that it is the liberty of the subject which is in question and I recognise that this is fundamental, but in my opinion, it is attained by other statutory provisions . . . These safeguards, and they will be reinforced if further recommendation of the committee become law, appear to be ample in themselves, and to be much more effective than the submission of a medical certificate to a Justice of the Peace. [PRO(NI), HSS 16/4/79, Appendix to recommendation 5]

Undoubtedly, he had the backing of many psychiatrists in Britain as well as in Ireland, but the government was not yet ready to make the final move on this issue. However, it was not long before it was being debated in Westminster. After the publication of the Report of the Royal Commission on Mental Illness and Mental Deficiency 1954-7, it was clear that most of the legal formalities surrounding treatment for mental disorder were about to disappear (Jones 1993, pp. 154-5).

We recommend that the law should be altered so that whenever possible suitable care may be provided for mentally disordered patients with no more restriction of liberty or legal formality than is applied to people who need care because of other types of illness, disability or social difficulty. Compulsory powers should be used in future only when they are positively necessary to override the patient's own welfare or for the protection of others. (HMSO, 1957, para. 70)

The right to treatment, rather than the need for protection would dominate the new era of mental health legislation. After the passing of the Mental Health Act 1959 in England, preparation began in Northern Ireland for similar legislation but no special committee was set up, as there was agreement in principle on the underlying ideology. Those who had been involved in the mental health services committee of the Health Advisory Council were thus happy to see judicial intervention removed from decisions on long-term treatment.

Two issues, however, which did arouse controversy during the Second Reading of the Bill in the Northern Ireland Parliament, were related to service development rather than to the protection of individual liberty. They were the omission of specific powers under which local authorities could develop community services, and the need for a special unit for mentally ill offenders. Echoing sentiments already expressed by Desmond Boal, a leading Belfast barrister and MP for Shankill, Senator Marion Greeves expressed her concerns on community care.

It has been stated that within a decade all the county mental hospitals will be closed. This disclosure of the future policy of the Hospitals Authority fills me with alarm and apprehension . . . These unfortunate people cannot be forced to live with relatives who do not want them. In the last resort they will be thrust on the welfare authorities, which will have to build new and expensive homes at great expense to the country. (NI Sen. Deb., 1961, Cols. 794-5)

Senator Greeves urged the government to make increased grants available to welfare committees to cover this heavy expenditure and remove 'an unfair burden from the already heavily taxed ratepayer'. However, despite these and other efforts by local councils to have extra resources allocated to them for community-based services, an amendment merely authorised a change

in the wording of the Welfare Services Act (NI) 1949, allowing for the inclusion of people suffering from a mental disorder among recipients of residential accommodation and domestic help (Sect. 81). As a result of this, community services were slow to develop, as welfare committees could ignore the amendment without fear of reprisal.

The second lobby – for the establishment of a special unit for mentally ill offenders – was more successful. The Act gave permissive power to the Hospitals Authority to provide special accommodation for violent or dangerous patients (Sect. 80); this was in response to the arguments of the Northern Ireland Association for Mental Health, the BMA (NI Branch) and the Mental Health Services Committee of the Hospitals Authority (NIHC Deb. 1961, Col. 2650), which were all similar – patients requiring a high level of security were an impediment to the ‘open door’ policies being encouraged in mental hospitals. While acknowledging the problem, the Ministry was opposed to building a special unit for offender patients because of the small numbers involved. During the only period when there had been a specially designated criminal lunatic asylum for Northern Ireland (at Derry Prison, 1930-45) the number had never exceeded eight. Consequently, the unit for dangerous and criminal mental patients did not materialise – rather, arrangements were made to transfer very difficult patients to Carstairs Hospital in Scotland.

The impact of the ‘troubles’

Political violence erupted on the streets of Northern Ireland in 1969. It followed two decades of relative peace and stability, during which, in spite of the decline of two major industries (shipbuilding and linen) and high levels of unemployment, there had been steady improvements in health, housing and education services. Since 1969, the civilian population have been exposed continually to different types of violent events, including bombs, riots, and sectarian killings. Newspaper articles such as the following are part of everyday life.

Loyalist gangs began petrol bombing the homes of Catholic families within hours of the IRA bomb massacre in the Shankill Road, the High Court in Belfast heard yesterday. Nine Protestants died in the blast on October 23rd and vengeance was wreaked on Catholics living in mixed estates in Lisburn and at Ballyduff, outside Belfast, a Crown lawyer said. (Irish Times, 16 Dec. 1993)

Though, it is difficult to believe that incidents such as these have little or no ill effects on the mental health of those directly involved as victims or indeed as perpetrators, the evidence so far is inconclusive. During the early years of the ‘troubles’ (1969-75), when levels of violence were at their highest, newspaper reports described a massive onslaught on psychiatric services.

A serious wave of mental illness has developed in Belfast as a result of last week’s rioting and continued tension. Doctors are reporting influxes of patients with mental breakdowns. In some cases, the symptoms are so severe that they have to be admitted to mental hospitals . . . one doctor in the Shankill Road area – the scene of one of Belfast’s most bitter fights – said he had prescribed more tranquillising drugs in the past five days than he usually does in a year. (The Guardian, 23 August 1971)

The academic literature, though, reveals a slightly different and more complex picture. Studies by R. M. Fraser (1971, 1974), a child psychiatrist working for the Northern Ireland Hospitals Authority, and H. A. Lyons (1971, 1972), a psychiatrist at Purdysburn Hospital, documented the immediate effects of the violence in 1969. Fraser (1974), in the first major study to examine the psychiatric sequelae of the violence, found that there was evidence of two types of psychiatric ill-health. The first, the 'acute emotional reactions seen in people who had been directly exposed to riot conditions', normally resolved when the violence ceased or when the person had received mild sedation. The second, psychiatric illness requiring admission to hospital, showed a significant increase 'only in areas adjacent to those affected by rioting'. Lyons (1971), in a study carried out during the most intensive period of rioting, from August 15 to the end of September 1969, found no increase in acute psychotic illness; those who developed symptoms 'tended to develop a short lived normal anxiety reaction or, in those with a previous psychiatric history, the illness pattern usually repeated itself'. In his second study, one year later, he examined the incidence of depressive illness in Belfast and suicide rates for the whole of Northern Ireland. A significant decrease was found in the incidence of depressive illness during the 1969-70 period, when compared with the 1964-8 period, while the suicide rate had dropped dramatically in 1970-2 at the same time as the homicide rate increased. He inferred from these findings that increased opportunities to externalise aggressive impulses reduced the incidence of depressive illness and suicide. In contrast to these findings, P. O'Malley (1969), psychiatrist at the Mater Hospital in west Belfast, found a significant increase in admissions of attempted suicides. The findings of these early studies have been disputed in the light of both later research in Northern Ireland and international literature on the effects of civil disorder, riots and terrorism (Loughrey & Curran, 1987; Cairns & Wilson, 1984, 1989). According to Loughrey & Curran, 'the international literature generally provides evidence against an increase in psychiatric morbidity or admissions during civil disorder or war', while Cairns & Wilson (1989) point out that one cannot draw any conclusions from the findings of either Lyons (1972) or O'Malley (1969), as suicide rates in England & Wales also dropped during the early 1970s.

Other studies, using rigorous methodology, found little connection between the political violence and psychiatric morbidity. For example, King *et al* (1977, 1982) carried out research on the prescription rates for psychotropic drugs. The second study, based on the computerised pricing data for prescriptions in Northern Ireland from 1966 to 1980, 'showed that the use of these drugs reached a peak in 1975, when almost 12.5% of the adult population, were estimated to have been receiving them, and declined in the following five years'. When compared with similar figures for other western European countries, the Northern Ireland prescription rates were not notably higher. The researchers concluded that there was no evidence of a direct relationship between tranquilliser prescribing and the severe rioting from 1969 to 1972, although they did acknowledge that the possibility of long-term effects could not be ruled out. To add to the confusion, Loughrey & Curran (1987), in a later retrospective survey of a large number of people who each had been a victim of terrorist violence, found that 60% had been prescribed tranquillisers, 42% hypnotics and 13% anti-depressants, and that approximately one-third of the total sample had taken psychotropic drugs

for longer than 12 months. This finding, which seems to contradict that of King *et al* (1982), is in keeping with international evidence (and indeed with early newspaper reports) that there is some evidence of an increase in the consumption of tranquillisers in urban areas during times of civil unrest.

It is very difficult to assess these studies because, not only has there been a change in the pattern of violence since the early 1970s, but also in prescribing patterns. Another factor is the extent to which evidence of emotional and psychological disturbance is sought. Victims of recent violence have been examined for symptoms of post-traumatic stress disorder (PTSD) as part of the process of claiming compensation, whereas this did not happen in the early years of the 'troubles'. Out of 37 survivors of the Enniskillen bombing, which took place in 1987, 50% had developed PTSD at six months and only one of these had recovered fully one year after the event (Curran *et al*, 1990). A number of questions arise out of this kind of result: Will the people suffering from PTSD recover without psychiatric intervention? How many of these people would have come to the attention of the authorities if there had been no possibility of compensation? Is it not likely, due to the nature of the violence in Northern Ireland (with a large number of the population rejecting the authority of the state), that a significant number of victims did not seek psychiatric help? Perhaps it is impossible to carry out comprehensive research in situations where not only the answers but indeed the research questions might put peoples' lives at risk. Maybe the long-term effects on the physical and mental health of people caught up in political violence can only be measured after the violence has ceased, when fear of reprisal is not a factor in either asking or answering questions (see Bryce *et al*, 1989; Yaktin & Labban, 1992; Summerfield & Hume, 1993).

Mental health policy since 1972

The past two decades have produced a mental health service which will form the basis for at least the early part of the next century. This service reflects the changes which have occurred in Northern Ireland since the early 1970s: a change in its political position following the imposition of Direct Rule in 1972, the reorganisation and integration of the health and personal social services in 1973, the introduction of management and planning systems throughout the health services during the 1980s, the reform of mental health legislation in 1986, another reorganisation of health service structures and the ideological shift toward a mixed economy of care in the 1990s.

Because the wider political context has had a major impact on recent health policies, it is important not to omit significant events from any historical discussion. In 1972, the worst year of violence (with 467 deaths and 4,876 injuries), several unsuccessful attempts were made to restore political stability [HMSO(NI), 1973; Harkness, 1983, p. 173]. The Northern Ireland Parliament (Stormont) was suspended, William Whitelaw was appointed as Secretary of State, and Westminster assumed direct responsibility for governing the Province. Since that time, in spite of two attempts to form an alternative governing body – the NI Executive (January to May 1974), and the NI Assembly (1982-6), Direct Rule from Westminster has continued. This has had a number of implications for health policies. For example, for ten years, public expenditure was consistently

higher in Northern Ireland than in other parts of the United Kingdom. In the mid-1980s, when many parts of England & Wales were already experiencing healthcare cut-backs, per capita levels of expenditure on health and personal social services were approximately 30% higher in Northern Ireland (Patten, 1984). Since then, however, the situation has changed and the financial advantage has almost vanished. Civil servants are now subject to considerable pressure to bring statistics on expenditure and service provision into line with those which prevail in other areas of the United Kingdom. Also, because (as yet) no public forum exists for political debate on changes in health policies or legislation, there is increasing convergence between mental health policy in Northern Ireland with that of England & Wales. The time-lag between the issue of policy statements in London and their implementation in Belfast has been getting shorter and shorter.

Services for mentally ill people have been dominated by hospital-based treatment for almost two centuries. Since 1961, when the number of psychiatric beds reached a peak of 6,486, admissions have increased, but the number of patients resident in hospital has fallen steadily. Initially, this trend was said to be due to 'changes in clinical practice and admissions criteria' [DHSS(NI), 1987, par. 4.17], but it was intensified in the late 1980s, as a result of government policy articulated in the *Regional Strategy for Health & Personal Social Services 1987-92*. The four Area Health & Social Services Boards were by then under pressure not only to reduce bed numbers, but to achieve a real shift in the balance of resources from hospital to community services [DHSS(NI) 1987, p 38]. The publication of the Griffiths Report on *Community Care* in 1988, and of the White Paper *Caring for People* in 1989, made the government's intention clear – the focus of care had to change to the community. The same message was repeated in – *People First: Community Care in NI for the 1990s*, published by the DHSS(NI) in 1990. During that year, it became apparent that though the number of patients resident in psychiatric beds had dropped to less than 2,500, there had been no reduction in the proportion of health and personal social services expenditure on psychiatric in-patient services (See Prior 1993, pp. 134-7). This was especially surprising in the context of Northern Ireland, where integrated health and social services boards and units of management provided the formal structures within which (theoretically at least) money could be easily transferred between health and social services. Embarrassing though it was, civil servants in the DHSS(NI) had to admit that an integrated service did not necessarily facilitate the release of resources from the hospital sector.

However, since 1990, two major factors have led to a rapid expansion in community based services. The first was another re-organisation of Health and Social Services Boards, allowing for the development of Trusts and for greater flexibility in the provision of services. The second was a further injection of DHSS(NI) funds (from the *People First* initiative) which brought the total amount allocated between 1987 and 1994, to facilitate the discharge of long-stay patients, to £39.5 million. (Donnelly *et al.*, 1994, p. 4). The result has been an expansion of creative day care – which includes advice, recreation, and therapy – and of residential projects (including hostels and sheltered housing). The current *Regional Strategy 1992-7* aims to further reduce the number of patients in psychiatric beds to 1,500 by 1997 [DHSS(NI), 1991, pp. 26,30]. Whether or not community based services will be adequate to meet the demands of these

people remains unclear. In the recent Health and Health Care Research Unit (at QUB) evaluation of the impact of community care policies on 509 long-stay psychiatric patients discharged since 1987, there are indications that though the patients are happier with their lives outside of hospital, there is no room for complacency. Some worrying findings were that staff in community based accommodation have been slow to engage in activities which might lead to greater independence among residents (because of the risks involved) and that patients in private nursing and residents homes (unlike those living in voluntary and statutory facilities) made relatively little use of extra-mural and peripatetic services such as social workers and community psychiatric nurses (Donnelly *et al.* 1994, chaps. 1 & 15). In other words, bridging funds may have been used in some cases to facilitate trans-institutionalisation, leading to a narrowing rather than a broadening of the patient's life experience.

The Mental Health (NI) Order 1986

Long before the Mental Health Act 1983 was passed in England, change was inevitable. The main criticism of the earlier laws (1959 in England & Wales, and 1961 in Northern Ireland) was that legal protection for patients had all but disappeared, because doctors had virtually unlimited freedom to make decisions which could deprive an individual of liberty. The campaign to increase patient protection was spearheaded by Larry Gostin of MIND (See Gostin, 1975) and led to a review of all mental health law throughout the United Kingdom. In Northern Ireland, the consultation process was quite comprehensive and involved not only the setting up of a special committee, the MacDermott Committee (1978-81), but also public discussion of the issues at the NI Assembly (in July 1985). The MacDermott Committee report was completed in 1981 and, though many of its recommendations were lost in ensuing discussions, two of the main differences between the laws in Northern Ireland and England originated in the work of this committee. In the former, compulsory admission to hospital is for assessment and the criteria for that admission much narrower than in the English Act.

An application for assessment may be made in respect of a patient on the grounds that : a) he is suffering from mental disorder of a nature or degree which warrants his detention in a hospital for assessment (or assessment followed by medical treatment); and b) failure to do so detain him would create a substantial likelihood of serious physical harm to himself or to other persons. [Mental Health (NI) Order 1986, Art. 4(2)]

In deciding on the grounds for compulsory admission, the MacDermott Committee was influenced by the philosophy of the American Civil Liberties Union, expressed in the legislation used in Massachusetts, USA. This philosophy is attributed to John Stuart Mill's statement on liberty - 'a man may do what he wills with his own life, provided that he does not cause harm to his fellow citizens' (Mill 1859, quoted in Jones & Fowles, 1984, p. 136). The MacDermott Committee, convinced by the American argument that Mill's concept of liberty should apply to people suffering from a mental illness, recommended very specific criteria for compulsory admission to hospital, but this was subject to intense opposition during the Assembly debate on the Draft Order. In written

and oral evidence, the National Schizophrenia Fellowship (NI) and the British Psychological Society (NI Branch) called for a return to the wording used in the 1961 NI Act and the 1983 English Act (NIA 1985a). This would allow for compulsory admission of a patient 'in the interests of his own health or safety or with a view to the protection of other persons' [Mental Health Act 1983, Sect. 2(2a)]. The objections were based on fear that the enforcement of strict behavioural criteria for compulsory admission might result in extra delay and distress to patients and relatives. The issue was hotly debated at the Health & Social Services Committee of the Assembly and at the main debate on the Draft Order. The DHSS(NI), surprised at the adverse reaction to the inclusion of a clause which had been strongly recommended by the MacDermott Committee, convinced the committee that the underlying principle was important enough to be upheld – that mentally ill people should be treated in the same way as physically ill people, insofar as this was possible.

As you know, people with a physical illness can refuse treatment; it does not matter if they need the treatment, or if they can benefit from it. Applying the same principle to the mentally disordered, we felt that the mere fact that you could treat a patient and that he would benefit from the treatment, was not in itself a sufficient justification for imposing treatment; that there had to be something in addition; and that something is the substantial likelihood of serious physical harm. (NIA, 1985a, App. XV, p. 40)

The reasoning behind the decision was clearly summarised by Paul Maguire (Alliance Party), a leading civil rights barrister and member of the Health & Social Services Committee of the Assembly. 'I believe that it is an important principle that liberty ought not to be denied, on a compulsory footing, save where there is objective medical evidence of a discernible risk of a compelling kind. The risk of a compelling kind, in my view, must be the risk of physical harm to a person's self or to others' (NIA, 1985b, p. 533). Because of the commitment of those involved in the preparation of this law, the Mental Health (NI) Order 1986 offers a high level of protection to a small but significant number of patients who do not willingly seek treatment. It does not, however, affect the lives of the majority of psychiatric patients, who have sought treatment voluntarily. For them, the shrinking hospital service is the source of greatest concern.

In conclusion

Having traced the development of services for mentally ill people from the establishment of the first district asylum at Armagh in 1825, through more than a century of hospital expansion which came to an end in the early 1960s, to the current era of community care, it appears that the direction of change often had more to do with the general socio-political context of services than with an assessment of need. Psychiatric beds increased from 104 in 1825 to over 6,000 in 1960, and then decreased to approximately 2,000 in 1995. As governments withdraw funding from the hospital sector, it is not certain that similar amounts of money will continue to be invested in community-based services. In Northern Ireland, the closure of at least some of the six psychiatric

hospitals built in the nineteenth century, is inevitable, but it is to be hoped that the twenty-first century will not see a return to a situation in which mental illness and vagrancy are synonymous.

Acknowledgements

I would like to acknowledge the invaluable research advice and guidance of Professor Kathleen Jones and the helpful editorial comments of Professor Hugh Freeman.

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16 The Evolution of Psychiatry in Glasgow During the Nineteenth and Early Twentieth Centuries

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This chapter describes the development of psychiatry in Glasgow during the century or so that followed the opening of its first designated hospital for the mentally ill in 1814. Against the background of psychiatry's emergence as a discipline distinct from general medicine, major changes in institutional provision for the insane in the region, as well as the careers of the principal medical men are outlined. Consideration is also given as to what extent one can define a coherent or successful Glasgow 'School of Psychiatry', and why (despite sharing many of the same advantages) psychiatry did not achieve the kind of cohesive identity and prominence as a discipline in nineteenth-century Glasgow that it did in Edinburgh.

Early Promise

The idea to raise funds and build an asylum in Glasgow arose out of the perception that the mentally ill were being inadequately cared for in the 'cells' of Glasgow's Town's Hospital (the City Poorhouse). Concern about the damp, cramped, and ill-designed nature of accommodation for the poor lunatics in the Town's and the degree of restraint being imposed upon them, had been growing for some years amongst the Town's Directors and others amongst Glasgow's governing classes. Disquiet had also been fostered by the activities of reformers in other centres (most notably by the example of the York Retreat). Led by one of the Town's Directors, the Glasgow sugar merchant, Robert McNair, a committee was formed to organise the raising of public funds from both parishes and private individuals in order to build an asylum (Andrews & Smith, 1993).

The Glasgow Asylum for Lunatics, designed by William Stark, opened in 1814 to wide public interest and acclaim. Its siting and design were very much inspired by the philosophy of 'Moral Management' pioneered by the Tukes at the Retreat. Stark published a pamphlet (Stark, 1807) outlining the thinking behind its panopticon design (first proposed in England by the Bentham's), and the heightened observational facility and classificatory distinctions – fundamental principles of moral therapy – that his building provided. With its four wings, radiating from a domed administrative centre, constructed so as to ensure 'a superintendence . . . which follows and watches every motion of the patient' with

the minimum of restraint, combined with a three-fold classification according to patients' class, gender and stage of illness, the building may be distinguished as the first truly purpose-built asylum in Britain. The four quasi-diagnostic divisions between patients were:- 'frantic', 'incurable', 'convalescent' and 'in an ordinary state' (Andrews & Smith, 1993, esp. pp. 25-50; S. Tuke, 1813, 1819; Hunter & Macalpine, 1963, pp. 445-6, 627-30, 747; Markus, 1982, 1988, 1989).

In the early days of the asylum, the medical influence was not predominant: the physician visited and was not resident. At the outset, it turned away many cases deemed 'incurable' and claimed for itself a high success rate, as measured by the discharges achieved. This original Asylum building, at Dobbies Loan, had accommodation for 100 patients and was to 'serve the people of Glasgow for two hundred years'. Some speculated that it would prove too large, but it soon became full to overflowing. A number of adaptations and additions expanded its capacity, but after only 25 years, plans were being made for a larger building at Gartnavel, and this move was made in 1843. The original Asylum building was subsequently taken over by the Town's Hospital.

The visiting physicians during these early years at the Asylum were Robert Cleghorn (1814-1819) and John Balmanno (1819-1840). In addition, Cleghorn combined a thriving private practice with the post of Visiting Physician to the recently opened Glasgow Royal Infirmary. As the Asylum and its turnover of patients grew, increasing demands were placed on the time of Cleghorn's successor, Balmanno, so that, towards the end of his period of office, he was doing little else but asylum work. Despite the clinical opportunities of the new asylum, however, neither of these men were to publish any writings in the field of psychiatry, and their main academic contributions and interest were confined to general medicine (Andrews & Smith, 1993, pp. 52-3; Duncan, 1896; Gibson, 1983; GARs, 1814-40).

The first resident physician was William Hutcheson, who oversaw the move to the new site. He was described by one of his House Surgeons as being the first in Scotland to champion the cause of non-restraint – a principle that was to be inscribed on the foundation stone at Gartnavel (Crawford, 1842). However, this rhetoric belied the reality, and the case records reveal that restraint was still being used even after 1843. Hutcheson left Gartnavel under a cloud, blamed for failing to prevent an outbreak of cholera in the hospital, and also, apparently, held partially responsible for irregularities in the Asylum accounts. In his last year there as physician, he also held the post of superintendent (GARs, 1840-48; Andrews & Smith, 1993, p. 54). The two posts were subsequently joined into one, as was then becoming the practice, and competition was to prove stiff for the first post of Physician-Superintendent (PS). One of the applicants was David Skae, already an incumbent of the equivalent post in Edinburgh (Glasgow Royal Asylum, 1849). (Perhaps the subsequent development of psychiatry in Scotland would have been very different if Skae were to have been appointed in Glasgow). The ultimate victor was Alexander Mackintosh, who was already a PS in Dundee, where he had previously defended the use of restraint (Dundee Asylum, 1840), but he seems to have become a convert to non-restraint after his translation to Glasgow.

Mackintosh was a devoted PS and, during his period of office, a number of innovations took place. Among these were skills-training for attendants (e.g. in the use of the catheter) and the introduction of night nurses onto the wards

(GARs, 1849-74; Mackintosh, 1889). Mackintosh was also distinguished for his early experiments with hypnotics and other drugs (GARs, 1866, pp. 27 & 42-3; 1867, pp. 25 & 42-3; 1870, p. 24; 1874, p. 39; T.H. Tuke, 1873, p. 332). With the assistance of his juniors, Mackintosh was one of the first in Britain to put a range of new medication to the test upon patients (including potassium bromide, chloral hydrate, and the hypodermic injection of morphia). In the main, though, his emphasis was on 'moral and intellectual treatment', tailored to the social standing of the particular patient. A conspicuous example of the "success" of such treatment is seen in the two cases of James Frame and John Adam, who both went on to publish books that praised the care they received (Frame, 1860, 1865; Adam, 1845). One of Frame's books, published anonymously, was dedicated to Mackintosh, but he was not unconditionally approving of the Glasgow medical establishment, reserving particular criticism for Hutcheson, who had treated him during an earlier episode of illness. Adam is of note in that he was allowed to stay on in the Asylum for some time beyond his recovery, until he could make new living arrangements, and in that he learned the use of the printing press there and was to set up in business as a printer after his discharge.

During Mackintosh's superintendence, the first visits to the Asylum by medical students were arranged. There was a great anxiety over this development, and numbers were initially kept small because of this. Mackintosh was also amongst those instrumental in setting up a Scottish Division of the Medico-Psychological Association (MPA), but his profile outside the asylum was an extremely low one. Despite his founding role, he was an infrequent participant at divisional MPA meetings. Aside from his annual reports, he made no published contribution to medical literature, seemingly too wrapped up in the day-to-day running of the Asylum. His name lives on in Glasgow psychiatry in that after his death his brother, Donald Mackintosh, bequeathed monies in his honour to finance both a lectureship and a prize examination for medical students. (The current Mackintosh lecturer is Dr Angus MacKay; R. D. Laing was a winner of the Mackintosh prize as a student.)

Psychiatric care outwith the Royal Asylum

Private Provision

By contrast with many large English cities, the Glasgow region (and Scotland in general) never seems to have experienced significant growth in private provision for the insane – commonly referred to in the English historiography as 'the trade in lunacy' (Parry-Jones, 1972). Five private madhouses appear to have been established in the area during the first half of the century, but by 1862 only two remained. Two of these houses were small and rather insalubrious establishments, quickly suppressed following the institution of new licensing and visitation regulations by the 1857 Lunacy (Scotland) Act. Another small house was abandoned by its proprietor after just five years, while the remaining two actually maintained more pauper than private patients. Throughout the century, most Glasgow families of means continued to provide for their lunatic members at home, or with guardians, or else took advantage of the mixed provision offered for both pauper and private patients by the royal asylum, and the new district

asylums established from 1864. It was as a result of the enduringly censorious disposition of the Scottish Lunacy Commission towards private establishments, that one of the two Glasgow madhouses remaining after 1862 was also to be suppressed, whereas the last was reconstituted as Glasgow's first District Asylum. The restricted nature of the private lunacy sector might have limited the opportunities for Glasgow medical men to make names for themselves by gaining psychiatric knowledge and experience outside the major chartered and parochial institutions. On the other hand, one could argue that the insignificance of the private mad trade in Glasgow should have allowed for greater security, cohesion and unity of purpose within the evolving psychiatric services, especially given the problems that had attended the private sector in the English context (e.g. the scandals of profiteering, ill-usage and false confinement). Furthermore, in England, the interests of the private mad trade had often proved competitive, or even hostile to those of the public sector.

None of Glasgow's private establishments seem to have attained a distinctive medical profile, or indeed to have fully emerged from their origins as lay undertakings, with medical men mostly of a low calibre or attending only in a visiting capacity. Four of the five private madhouses set up in the Glasgow region during the nineteenth-century were off-shoots from the Glasgow Asylum itself, in that they were established and run by former members of its staff. The first seems to have been Garngad House in Glasgow, which was opened by the Asylum's original superintendent, William Drury, who resigned, with his wife, in 1823. Drury went on to obtain his M.D. from Glasgow University in 1840, while, on retiring in 1850, he passed on Garngad's management to Dr James Hill. Yet neither of these men was to establish an influential standing in the field, or to publish the results of their clinical experience. Nor was Garngad or any other of Glasgow's private asylums ever to achieve wider repute or status for any alternative mode of treatment they had to offer. At its height, Garngad housed around 80 patients, with a staff of 20, and initially seems to have been well regarded by visiting inspectors. However, it was eventually closed by the Lunacy Commission in 1872, ostensibly because its amenities and site were inadequate. Hill was also criticised by the Commissioners for his 'penal' use of the bath.

Like Drury, Hugh Aird Galbraith, Superintendent and Apothecary at Glasgow Asylum during 1827-38, also quit his asylum practice for the private mad business, opening Mansion House at Dalbeth in 1839. While the Lanarkshire Sheriff praised the house's accommodation as 'far superior to any others of the kind . . . in Scotland' (Glasgow Asylum, 1964), the enterprise was to be abandoned in five years, on Galbraith's removal to the Isle of Bute. The only Glasgow establishment specifically for females appears to have been Springbank Retreat, a small private house for insane ladies, run by Miss Berry and Miss Anderson. The former had previously been Assistant Matron at Glasgow Asylum. In addition, from c1845, the enterprising Miss Anderson also kept Blackfaulds Asylum, in Rutherglen, with accommodation for one man and four women in 1855. Both houses received only a handful of cases, however, with a medical man visiting just once a week. Providing accommodation deemed 'untidy', 'dirty', 'bare and cheerless', or 'illkept' and 'disorderly', on visits by the Lunacy Commission, both were soon closed (GBLCS, 1857, 1859-62).

The only other private asylum in the Glasgow area was Longdales House, Bothwell, which opened in 1848 and housed between 90 and 130 patients,

pauper outnumbering private patients by roughly 10:1. The Proprietor and Resident Physician was Dr Henry Muirhead, who had been Assistant Superintendent at the Glasgow Royal Asylum prior to this venture. A rather unremarkable proprietor, Muirhead published little or nothing in the field of mental science, and sold up in 1869 to Dr William Dean Fairless. Fairless demolished the building and rebuilt it in a more contemporary red sandstone style. While Fairless was a rather more distinguished incumbent, having published on the design of asylums in 1861 and previously worked as Medical Superintendent at Sunnyside Royal Asylum, he was to publish nothing else of note and to make a very limited contribution to raising the profile of the private sector in Glasgow. Nevertheless, he remained an active member of the MPA in Scotland, and his continued regard in psychiatric circles is reflected by the fact that his obituary (Fairless, 1888) was written by the renowned Gartnavel PS, David Yellowlees (for more on whom, see *infra*).

The Parochial and District Asylums

For most of the nineteenth-century, care for the mentally ill continued in the poorhouses – the equivalent of the English workhouses. Glasgow Asylum had been opened to replace this provision for lunatics in the city, but it had never been able to cope with the numbers concerned, while its prioritisation of ‘curable’ cases saw a steady stream of chronics being sent back to the Town’s. Indeed, on its first day of opening, the Asylum had returned four of the 41 patients sent from the Town’s as ‘incurable’.

In the 1840s, when Glasgow Asylum moved to the new buildings at Gartnavel, the Town’s Hospital itself transferred to the building of Stark’s Asylum. It was continually criticised by the Lunacy Commission for its poor location and lack of amenities in the subsequent years (GBLCS, 1859-1900). Glasgow was undergoing a rapid expansion during this time, and a building which had originally been at some remove from the city had now been surrounded by it. The population which it was serving was also growing at an inordinate rate, increasing between 1841 and 1911 by roughly one million, with inward migration of workers (to serve the growth in heavy industry) contributing greatly to this.

Given this population growth, the need to replace the poorhouse provision became more and more pressing (e.g. Barony Asylum, 1870). The three main parishes in Glasgow (City, Barony, Govan) each had their poorhouse, with the mentally ill (housed in poorhouse ‘lunatic wards’) comprising a large portion of the inmates. Following the 1857 Lunacy (Scotland) Act, these institutions required to be officially designated as fit for the care of the mentally ill and to be subject to inspection by the Lunacy Commissioners. The need for new building was slow to be acknowledged by these parishes, but eventually had to be faced. Woodilee Hospital (Barony Parochial Asylum) opened in 1875. Langdales was bought by the City Parish and became Glasgow District Asylum in 1881, being replaced by Gartloch Hospital in 1897. The Govan District Asylum at Hawkhead (now Leverndale Hospital) opened in 1895, but there had also been provision prior to this for Govan at Merryflatts (now the site of the Southern General Hospital) from 1872 (Christie, 1888; Watson, 1888; Govan Asylum, 1964). During

the last quarter of the nineteenth century, the Glasgow Royal Asylum for Lunatics under Yellowlees was to pursue a policy of transferring all its pauper patients to these new District Asylums in Glasgow and the surrounding districts (including the District Asylums in Argyllshire, Lanarkshire, and Paisley).

Medical Officers at Parochial and District Asylums

The ascendancy of medical authority at the Royal Asylum in Glasgow and other chartered asylums in Scotland, was a rather slower and more troubled process in the context of parochial institutions catering for lunatics (i.e. in the lunatic wards of poorhouses, some of which were established latterly as separate parochial asylums). For example, during the 1850s, the Barnhill Poorhouse (which catered for Barony's pauper mentally ill in its lunatic wards), soon acquired a poor reputation for its rapid turnover of medical staff, portrayed in the local press as symptomatic of the Barony Board's disregard for the opinions of its medical men and for the mental and physical health of the inmates (Barony Asylum, 1856-70; Mckenzie, n.d.). These controversies also gained considerable publicity because two successive medical officers published lengthy indictments of the Parochial Board's dealings with them, as well as of its running of the poorhouse in general and the lunatic wards in particular (Milner, 1858; Mather, 1858). While some of this may be attributed to political rivalries and factions within the district, in which the local press took different sides, medical posts at these poorhouses and their lunatic wards were generally low in prestige. Medical officers were regularly frustrated by the interference of lay officials in their prescriptions, and by the failure of parochial boards to endorse their authority over the health of inmates and other matters they viewed as within the competence of the medical department. Indeed, there appears to have been a tendency for these medical officers to be sacrificed as scapegoats when internal dissensions broke out and there was outside criticism of inadequate care.

However, medical posts at new parochial and district asylums, which were managed by the newly created District Lunacy Boards, were to prove more secure and prestigious. The creation of these asylums – in part a response to the apparent increase in pauper lunacy – also allowed for the expansion of psychiatry as a profession, and saw the emergence of rather more prominent medical figures at their heads. For example, the first PS at the new Barony Parochial Asylum (later Woodilee Hospital) was James Rutherford (1874-1883). He had previously been in charge of Argyll and Bute District Asylum (1870-1874) – the first of Scotland's District Asylums – and subsequently took charge of the Crichton Royal Institution (1883-1907). He was to become a distinguished alienist, co-translating Griesinger's *Manual of Mental Diseases* (Griesinger, 1867) with C. L. Robertson and acting as Honorary Secretary to the Scottish MPA.

Another distinguished practitioner of this time, was Alexander Robertson, from c1858 PS at the Town's, or Glasgow's City Parochial Asylum. He was one of the most productive of the Glasgow nineteenth-century alienists, if measured simply by the volume of his publications. Publishing on a wide variety of topics, Robertson made particularly important contributions in the area of neuropathology, especially in his work on aphasia and epilepsy. An early convert to localisation theories of mental function and pathology (e.g. Robertson, 1878a,

1879, 1897), which related specific mental functions and diseases to specific areas in the brain, Robertson related the loss of speech in aphasia to 'a lesion in the motor conductors for articulation' (Robertson, 1866a). On the other hand, he parted company with the likes of Broca, Müller, Trousseau, and others, whose work on aphasia stressed the existence of – and assumed damage to – a faculty of language in the brain. Robertson also provided evidence against the prevailing view (partially endorsed by Müller's and Trousseau's theories) that speechlessness in aphasia was caused by 'forgetfulness of words', arguing for the residual reasoning capacity of aphasics and emphasising cases of recovery (Robertson, 1866, 1869a, 1876, 1879b). Indeed, Robertson had a good claim to priority for his early work on aphasia, which he was at pains to assert (Robertson, 1876).

Robertson's research into paralytic afflictions (Robertson, 1865, 1873, 1893a, 1895, 1896a), epilepsy (Robertson, 1877a, 1878b, 1883, 1894a) and unilateral phenomena in mental illness (Robertson, 1869a, 1875a, 1877b, 1892c, 1901) had sprung from similar views about such disorders as illustrations of 'cortical localisation'. His work on epilepsy was especially important, and was cited by Hughlings Jackson (1876). Like many others in the Glasgow School, Robertson saw neuro-pathological research in psychiatry and the lessons of localisation as the key to future progress. Indeed, it was in this area that the Glasgow School appears to have achieved its greatest coherence and to have had its greatest impact. In addition, he was a keen therapeutic experimenter, using the Town's as a base for testing a wide range of old and new therapies, from hypnotism and galvanism to electricity, hydro-therapy, and thyroid-extract treatment (Robertson, 1871b, 1871c, 1887, 1890, 1891a, 1895, 1896b, 1896c, 1897a, 1897b). Alongside Rutherford, Robertson was also a vocal proponent of the non-restraint philosophy.

Another prominent Glasgow alienist was Archibald Campbell Clark, who was to serve as Medical Superintendent of the Glasgow District Asylum (Bothwell) between 1880 and 1896. Clark had been trained in Edinburgh and had served as Assistant Physician at the Royal Edinburgh Asylum just prior to this appointment. While not as productive as Robertson, he also published on a wide variety of topics, including hydrocephalic imbecility, experimental dietetics, and thyroid feeding (Clark, 1879, 1887, 1898a & b). His contributions on the relationship of insanity to sexual and reproductive function were particularly highly regarded (Clark, 1883, 1887-8, 1888, 1897, 1899). Clark also exerted considerable influence in the training of asylum attendants, his activism and publications on the issue whilst at Bothwell being instrumental in the establishment of MPA examinations and asylum training programmes for attendants, as well as the publishing of the MPA's Handbook for Asylum Attendants (Clark, 1884, 1886). He also taught as Mackintosh Lecturer at St. Mungo's College (the incorporated extra-mural college into which Glasgow Royal Infirmary's medical school was converted in 1889) and was the only nineteenth-century Glasgow psychiatrist to produce a textbook of general psychiatry. His *Clinical Manual of Mental Diseases* (Clark, 1897) was, however, not well received by the medical press of the time (*Glasgow Medical Journal*, xlviii, 1897, pp. 385-6).

On the other hand, many junior medical officers who cut their professional teeth at these Glasgow asylums failed to go on to achieve senior positions within psychiatry, or even to specialise in psychiatry at all. Many opted for careers in general medicine, both in the general hospitals and infirmaries of the district,

and as parochial medical officers, or else preferred the better remuneration offered by private practice. Many did not remain in Glasgow at all, but moved on to more attractive posts elsewhere in Scotland, or further afield – emigrating to Australia, New Zealand, and other colonies, by the end of the period. It seems to have been common for such men to employ a period in an asylum as a stepping stone to a better career, prior to any decision to specialise, and better opportunities seem more often than not to have existed outside of psychiatry's ambit. Indeed, a further reason for the limited achievements of the Glasgow School may be this tendency for career paths to wander off the discipline's track at an early stage, and the failure to nurture young trainees adequately through to the leading positions at British psychiatric institutions.

The careers of those who had formerly acted as clinical clerks and assistant medical officers at Gartloch, Glasgow's District Asylum, during 1897-1913 (between its opening and the start of the First World War) illustrate these trends very well (Gartloch Asylum, 1914, pp. 48-9). Over 87% of Gartloch's clinical clerks had gained their degrees or licentiates from Glasgow (one was also an FRCS of Edinburgh), one had graduated from both Edinburgh and Glasgow, two from Glasgow and Cambridge, and just two from completely outside Glasgow, having obtained London licentiates. By 1913, however, only three of these former clerks had gained or retained posts at Glasgow hospitals, only two of whom had posts in asylums, and both of these were recent trainees. Nearly 62% of clerks had gone into private practice, and in only four cases in the West of Scotland (three in Glasgow and one in Rutherglen). Fourteen had settled down to private practice in England, and two in Wales. Nine had emigrated to institutional or army medical posts, or to private practice in the colonies: five to Australia and New Zealand, two to India and two to Africa. Amongst all 39 of Gartloch's former clinical clerks, only nine had remained in the West of Scotland.

Amongst assistant medical officers, the pattern was similar. Eleven out of sixteen, had gained their degrees in Glasgow (one was also FRCS Edin.); three had graduated from Edinburgh, one from St. Andrews, and only one from outside Scotland (London). Once again, most assistants left asylum service for private practice, only two setting up practice in Glasgow, one moving to Dundee, four to England, one to New Zealand, and one to South Africa. A somewhat larger proportion than that amongst clinical clerks achieved posts within psychiatric institutions in Glasgow, one becoming Medical Superintendent at Gartloch itself, another at Barnhill Poorhouse (which had retained its asylum ward), and another at Stonevetts Epileptic Colony near Glasgow. In addition, one assistant gravitated to the post of pathologist at a Glasgow hospital, while another became Medical Superintendent at an Australian hospital. On the whole, however, these data suggest a pronounced propensity for Glasgow medical graduates to eschew asylum practice. This may on its own provide one explanation for the failure of psychiatry in the West of Scotland to achieve a distinctive identity, or to develop a coherent scientific community on a par with that at Edinburgh.

However, in many other cases – particularly higher up the ladder of asylum medical hierarchy – medical education was less parochially rooted to one particular centre. Indeed, many of those who spent some part of their careers within the Glasgow School trained and worked at other centres also – for instance, Mackintosh at St. Andrews and Dundee, and Hutcheson, Yellowlees, and Clark at Edinburgh. This was true even amongst some of the lower-ranking

posts. For example, William Eadie, Anthony Butler, and Hugh Murray, who served as Physician and assistants (respectively) at the Town's in the 1870s and 80s, all trained at other centres as well as, or instead of Glasgow (Edinburgh, Aberdeen, Paris, and Berlin). All had previous posts as assistants or surgeons in general hospitals and left psychiatry for posts as parochial medical officers and factory surgeons, or for private practice. As far as a school of psychiatry can be defined merely as a place of training, or the locus of a practitioner's subsequent practice, there is often no clear point of demarcation as to where one begins and another ends. Indeed, any clear-cut distinction between the Glasgow and Edinburgh Schools must be something of an artificial construct, when members of both trained and worked at both centres.

Phrenology at Glasgow and Edinburgh

The place of Edinburgh and more especially of the Edinburgh brothers George and Andrew Combe, in the history of phrenology is now well known to historians, thanks especially to the work of Roger Cooter (Cooter, 1976, 1984). W. A. F. Browne also studied at Edinburgh, where he became a keen devotee of phrenology and of the Combes. Indeed, a scientific community grew up in Edinburgh around these phrenologists and their work, with the Edinburgh Phrenological Society, the Society's *Transactions* and *The Phrenological Journal and Miscellany*, and the Combes' Museum of Phrenology all being established there between 1820 and 1847. That great doyen of the psychology or philosophy of mind, Sir William Hamilton, also lectured in Edinburgh from the 1830s, beating Andrew Combe to the University's chair of Logic – although his repudiation of the view that psychology should be anchored on the correspondence of mind and brain was to prove one of a number of nails in the coffin of phrenology.

Glasgow followed Edinburgh to a small degree in the development of an interested medical community around the study of phrenology. A number of Glasgow Asylum's medical officers were members of the Phrenological Society, including Hugh Aird Galbraith, Superintendent and Apothecary during 1827-38 (Glasgow Royal, 1964) and Alexander Mackintosh, Gartnavel's second PS. When Galbraith applied for the PS post at Manchester (Cheadle Royal) Asylum in 1849, one of 25 signatories on the testimonial was Dr. William Weir. Weir had been Professor of Phrenology at Anderson's University Medical School (another of the extra-mural schools, established in Glasgow in 1796 by the will of John Anderson, who had held the Chairs of Oriental Languages and Natural Philosophy at Glasgow University) since 1846, and was to serve as a Director of Glasgow Royal Asylum during 1851-2 (Glasgow Royal Asylum, 1964). The momentum for his lectureship, however, had not surprisingly come more from Edinburgh, as the British capital of phrenology, than from Glasgow. The lectureship had been endowed by the will of W. R. Henderson, a former patient of Andrew Combe. On its inauguration by Weir in 1846, Combe, as one of Henderson's Trustees, had written an address, which was read by his brother George (Combe, 1846). Mackintosh had been associated with Andrew Combe and his work since his Dundee days, and his annual reports at Gartnavel testify to his continued interest in phrenology. Combe had acknowledged Mackintosh's work in his renowned *Observations on Mental Derangement*, emphasising how important was a wide range

of occupations for asylum inmates, and illustrating his point with examples from Dundee Asylum under Mackintosh (Combe, 1888; *Journal of Mental Science*, April, 1888, pp. 124-5). By the 1850s, however, phrenology was already on the wane as a serious interest for alienists and medical men in general. Weir, while remaining a member of the Glasgow Phrenological Society and editing the *Glasgow Medical Journal*, made no real contributions to mainstream psychiatry. His official duties as Physician to Barony Fever Hospital and subsequently to Glasgow Royal Infirmary were all outside the discipline. He tended to concentrate, as his career progressed, on clinical medicine and on his lectures on medical practice at Portland Street Medical School (another of Glasgow's extra-mural schools, now part of Strathclyde University) and on clinical medicine at the Infirmary. Indeed, all things considered, there was nothing in Glasgow to compare with the vigour of the Edinburgh phrenological school in the 1820s, 30s, and 40s.

The great figurehead of phrenology in Glasgow in later years was James Coates. Coates did not possess a medical degree and was not registered in the *Medical Directory*, but was editor of *The Phrenological Annual and Record*, a conciliar member of the British Phrenological Association (BPA), and published widely on phrenology. Coates also lectured on mental science and hygiene in Glasgow. He was an important populariser of the work of Combe and Gall, at a time when phrenology was increasingly in decline as a legitimate pursuit for medical men. His best-known work was perhaps his collection of lectures *How to Read Heads* (c1890), a copy of which he presented to his old friend, John Gray McKendrick, the renowned physiologist, who was successively Professor of Physiology at the Royal Institution of Great Britain, and of the Institutes of Medicine and of Midwifery & Practical Physiology at Glasgow University. McKendrick's interest in psychiatry is testified to by the many books and articles donated to him by Glasgow alienists. Providing encouragement and guide-lines to others on how to set themselves up in practice as phrenologists, Coates' writings stressed the practical applicability of phrenology, but less to mental or any other medicine than to the rather more amorphous 'reading of character'. Indeed, Coates gave private instruction and public courses at Crosshill on the theory and application of phrenology, assisting students to qualify for the Diploma of the BPA, and advertising his own and others' teaching and publications in *The Phrenological Annual*. Coates' wife, Jessie, was also a professional consulting phrenologist and examiner, having gained her BPA Diploma with James' encouragement. Coates' work is itself, however, something of a nostalgic testimony to the apogee of phrenological enthusiasm in the 1840s, whereas the discipline had become a rather disreputable sideline for alienists by the 1870s-90s.

Glasgow psychiatry and Dr David Yellowlees

Psychiatric Teaching in Glasgow

In evaluating the vigorous emergence of psychiatry in Edinburgh as a discipline, historians have tended to emphasise the development of psychiatric teaching there. Indeed, commencing with the courses offered by Alexander Morison, through to David Skae and the ultimate integration of psychiatric teaching into the University Medical Faculty, with Clouston's appointment as Lecturer

on Mental Diseases in 1879, the Edinburgh School has been portrayed as a thriving nursery of psychiatry. It produced some of the most prominent and successful of Britain's nineteenth and early twentieth century alienists (G. M. Robertson, 1928; Fish, 1978; I. Smith, 1990; Beveridge, 1991; James, 1991).

In some sense, developments in Glasgow mirrored those of its eastern neighbour. The Glasgow Royal Asylum's second PS, Dr. David Yellowlees (1874-1901), had been partly attracted to Glasgow by the possibility of involvement with formal psychiatric teaching at the University. Yellowlees had trained in Edinburgh and under Skae, alongside Clouston, and was employed at the Glamorgan Asylum as PS before coming to Glasgow. The establishment of a psychiatric lectureship was, however, to prove politically sensitive within the University Medical School. It was 1880 (six years after his arrival as PS) before Yellowlees was appointed as the first Lecturer in Mental Diseases there. Prior to this, psychiatric teaching had been subsumed within the course on general medicine and the lectures given by William Tennant Gairdner, Professor of Medicine. Gairdner was supportive of Yellowlees and was willing to give up his 'few' lectures in his favour. Yellowlees' friendly relationship with Gairdner (his former teacher), and the earlier collaboration of Gairdner and Mackintosh in psychiatric teaching – with Glasgow Royal permitting medical students from the Infirmary to gain clinical experience on the asylum wards – no doubt encouraged continuing cooperation. Despite this, the Medical Faculty insisted that Yellowlees' teaching would be: 'without prejudice to the rights and privileges of the chairs of the Practice of Medicine and of Forensic Medicine or to those of any other chair embracing the subject of insanity' (Burns, 1984).

The final form of Yellowlees' course was a series of 12 short lectures, which were, in part, simply 'afternoon clinics' (*Journal of Mental Science*, Oct., 1881, p. 455). Gairdner records that these courses were well attended although not compulsory for medical students until 1892 (Yellowlees, 1904). Yellowlees continued as Lecturer in Mental Diseases until 1905, when Landel Rose Oswald took over the post as the next PS at Gartnavel (1901-1921).

Psychiatric teaching was also being carried out at St. Mungo's College from 1876 by Alexander Robertson (Robertson, 1872, 1877d), while Robertson's teaching of Gairdner's Glasgow Royal Infirmary students on the wards of the Town's reveals a similar collaboration as that between the Infirmary and Gartnavel Royal. In addition, from 1891, lectures were being given at Anderson University by John Carswell (Burns, 1984), but these courses were not recognised by the Medical Faculty until 1898.

The Classification and Diagnosis of Insanity

Another area of particular prominence for the Edinburgh School of Psychiatry in this period was its contributions to the diagnosis and classification of psychiatry. Although historians have tended to emphasise the shortcomings of the classificatory system devised by Edinburgh Royal's David Skae, Skae's system clearly had considerable influence on his contemporaries, particularly those who had trained at Edinburgh (Crichton-Browne, 1875; Fish, 1978; Beveridge, 1991). It was founded along developmental and (presumed) aetiological lines (Skae, 1863, 1873). Most importantly, his star pupil and successor, Thomas Clouston,

emerged as a champion and adaptor of the system, ensuring both broad coverage and continuity for Skae's approach. Furthermore, this emphasis on classification was carried through to the level of clinical practice at Edinburgh Royal, as its highly structured case-notes and admission records make only too clear.

By contrast, although the keeping of clinical case-notes (a rather later development in Edinburgh) was introduced from the start at the Glasgow Asylum for Lunatics, little use was to be made of the clinical material so collected in nosological thinking. For the first 60 years there, the classification system used was based on the Pinelian schema, as adapted and popularised by Esquirol. Balmano did lay out a more sophisticated classificatory scheme in his 1840 Annual Report, but the various diagnostic categories were not explained and, when one looks at the case-notes, the system does not appear to have been put to use. Likewise, Hutcheson, despite being vocal on a large number of issues in his annual reports as Physician, failed to proffer any classification of his own. However, he did arrange for the copying of his predecessors' casebooks, and, reading through them, made his own comments and points of criticism on clinical matters in parenthesis. The diagnostic system was kept simple and descriptive (or symptom-based), therefore. Indeed, for much of the period, Glasgow Royal's practitioners seem to have shared in the scepticism of many other established alienists, like George Man Burrows, towards the utility of complex nosologies in mental medicine (Burrows, 1828, p. 258).

As a former assistant of Skae's at Edinburgh, on the other hand, Yellowlees was plainly influenced by the former's thinking on diagnostic classifications, as can be seen in his academic and pedagogical writings. In one article, he laid out his own nosological model, founded very much on Skae's principles of aetiological priority (Yellowlees, 1881a). In general, however, Yellowlees proved a cautious diagnostician, rather critically disposed towards the clarity and authenticity of popular new diagnoses such as Clouston's 'phthisical insanity', Hughlings Jackson's 'epileptic insanity', and even general paralysis of the insane (GPI) (Clouston, 1887, pp. 465-79; *Journal of Mental Science*, July, 1883, p. 319; April, 1877, pp. 141-2). Yellowlees' own commitment to a classificatory schema was tame by comparison. The Gartnavel Royal case notes normally failed to record any clear-cut diagnosis, and were characterised by their relative lack of structure. While diagnoses appear in the admission registers in a more 'modernised' set of sub-classifications, they also reflect the resilience of traditional paradigms and practice, with mania and melancholia continuing as the main diagnostic categories. This state of affairs was to continue through to 1921, when Dr. David Henderson, taking over as PS, brought in the Kraepelinian system that has since predominated. The late adoption of such a system in Glasgow was something of which Henderson was particularly critical.

Yellowlees and changes at the Glasgow Royal Asylum

Yellowlees' general approach to psychiatry could be characterised as one of pragmatism. He was deeply suspicious of 'system' in psychiatry, believing that each case should be judged on its own merits, and that his colleagues were too prone to reducing observed phenomena to their own pre-existing presumptions. This was also reflected in the fact that he seems to have been most noted in his

day for his practical contributions to the preventive treatment of masturbation among patients (wiring the prepuce) and for the device he devised for artificial feeding (Yellowlees' bottle) – subjects on which he was recognised as sufficiently expert to write the entries in Tuke's *Dictionary* (Yellowlees, 1892). Some of the case records at Gartnavel bear testimony to Yellowlees' interest in these areas.

Under Yellowlees, Gartnavel Royal gradually discharged all its pauper patients, transferring them to the new District and Parochial Asylums (Lanark (Hartwood) District Asylum, Woodilee, etc). The ideal asylum for Yellowlees would be small, allowing the medical attendants to have individual knowledge of their patients. While Yellowlees exerted himself to convert Gartnavel Royal into a hospital for acute, curable cases, he also campaigned for the segregation of chronic incurable cases, preferably in separate chronic hospitals. Both of these developments, he held, would promote the possibility of progress in research into the nature and treatment of mental illness. In general, however, Yellowlees was markedly ambivalent in his attitude towards the 'hospitalisation' movement in late nineteenth-century psychiatry – so strongly supported by Clouston and Robertson in Edinburgh (Macpherson, 1896; G.M. Robertson, 1922). While fully prepared to advocate the installation of mental observation wards in general hospitals, and other key aspects of hospitalisation, Yellowlees was very critical of reforms suggested by colleagues like Maudsley and Whitcombe, who were agitating for teaching hospitals as a vital step to revivify psychiatry's failings in clinical research into the causes and treatment of insanity (*Journal of Mental Science*, Oct., 1889, pp. 455-66 & Oct., 1890, pp. 585-7 & 590; Yellowlees, 1890; Maudsley, 1895). On the contrary, argued Yellowlees, patients would be far more appreciative of good care and attention than they would of trendy new treatments and the paraphernalia of scientific research. This may help to explain why the earliest steps taken in these directions in the Glasgow region are to be found at the new parochial and district asylums, like Woodilee (constructed with both an asylum and hospital ward), and Gartloch (which was designed with observation wards, pathological rooms, and most of those features emphasised by authorities like the Scottish Lunacy Commission as essential for the new hospitalised environment of the asylum). Yellowlees' scepticism as to how far such arrangements would prove useful seems characteristic of his pessimism in general as to the prognosis of most cases of insanity (e.g. his criticisms of statistics from other institutions claiming high 'cure' or 'recovery' rates). In this disposition, he seems to have differed somewhat from other Glasgow psychiatrists, like Carswell and Clark, who were much keener in their espousal of hospitalisation – Carswell advertising far and wide the benefits of the observation wards at Barony in restricting the increase of chronic lunatics afflicting other areas (Carswell, 1891-1894b), and Clark having a large hand in the designing of Lanark District Asylum at Hartwood along 'hospital' lines (*Journal of Mental Science*, Jan., 1890, pp. 135-9).

Disagreements over restraint and open-doors

These differences between Glasgow alienists over hospitalisation may hint at another explanation for the failure of the Glasgow School of Psychiatry to forge a cohesive identity in this period – the existence of significant discontinuities and

divisions of opinion amongst its more prominent members, especially during the latter part of the nineteenth-century. Divisions were particularly profound amongst Glasgow alienists over the issue of restraint. A long tradition of espousal of the non-restraint cause in Glasgow had begun in the 1840s, beginning with Hutcheson and young, idealistic practitioners like John Crawford, a medical assistant at Glasgow Royal who devoted his MD dissertation to the subject (Crawford, 1842). While in one sense this tradition was continued through to the 1880s, with Alexander Robertson's championship of the cause, he having been 'trained in its practice' (*Journal of Mental Science*, April, 1889, p. 142) under Glasgow Royal's Alexander Mackintosh, Yellowlees' accession to the superintendent's post marked a radical departure in this respect. While Yellowlees' sympathy towards the pragmatic uses of restraint and the developing controversy between Glasgow alienists on this issue reflected broad changes in psychiatry as a whole (Tomes, 1988; Suzuki, 1995), the differences of opinion seem to have been especially acute in the city.

Yellowlees' 'advocacy' of restraint had begun in his Glamorgan days, and was further outlined in letters to the *Lancet* (Glamorgan AR, 1872; *Journal of Mental Science*, Oct. 1873, pp. 435-8; Yellowlees, 1872). After his move to Glasgow, arguments over the issue reached a new level of intensity, played out and publicised through meetings at the MPA, in the pages of its periodical, the *Journal of Mental Science*, and in the annual reports of different asylums (Yellowlees, 1889; *Journal of Mental Science*, Jan., 1889, pp. 621-9; April, 1889, pp. 137-42; July, 1889, pp. 286-7; Oct. 1889, pp. 415, 475-9; GARs 1874-1901, esp. 1887). While Robertson on the one hand, supported by other Glasgow practitioners like Rutherford, launched a frontal attack on what was conceived as a 'retrograde movement' against the sacred principles of Conolly, of which Yellowlees was 'the leader in Scotland', Yellowlees responded by admonishing those 'sacrificing the patient to a sentiment'. He had warned elsewhere that an asylum was like a 'volcano' and the possibility of homicide or suicide amongst its residents (against which restraint was a necessary safeguard) was ever present (80th GAR, 1893, p.12). While commencing peaceably enough, the argument was to grow rather more acid, with Robertson asserting that Yellowlees had departed 'distinctly and definitely' from that principle [of non-restraint] and berating him for failing to come clean about his restraint record, while Yellowlees accused Robertson of being over-zealous and outrunning his master. Yellowlees' characterisation of Robertson as an 'extremist', indulging in '*reductio ad absurdum*', can have only widened the rift between the two men (*Journal of Mental Science*, Jan., 1889, pp. 621-9; April, 1889, pp. 137-42; Oct., 1889, pp. 475-9, and Jan., 1890, p. 154). Yellowlees' annual reports, in which he denigrated 'blind or bigoted adherence to any so-called system', were highly coloured by his confrontations with Robertson and others (GAR, 1887, p. 111).

Consistent with this position, Yellowlees was also rather negatively disposed towards the open-door system which was being introduced elsewhere and pioneered in Glasgow in particular by Rutherford at Woodilee (1871 Annual Report of Fife & Kinross District Asylum; *Journal of Mental Science*, Jan., 1872, pp. 624-5; J. B. Tuke, 1881). He was also a sceptic about the practice of boarding-out mental patients, which had become such a characteristic part of the mixed provision for the mentally ill in Scotland, and was broadly endorsed

by Robertson, Rutherford, Carswell, and others from the Glasgow School (e.g. A. Robertson, 1870, 1888; Carswell, 1891-94b).

Forensic Psychiatry in Glasgow

In forensic psychiatry too, the Glasgow School also seems to have had a lesser impact than that in Edinburgh. An early textbook in the field, *The Medical Jurisprudence of Insanity* (1843), was produced by Dr John M. Pagan, as a development of a series of 'extra-curricular lectures' given by him. While stating a claim for originality as a 'comprehensive' guide to the subject for 'the student' (*ibid*, p iii), Pagan's book was preceded and surpassed by a handful of other, more widely read works (Johnstone, 1800; Cox, 1806; Haslam, 1817; Ray, 1838 & Pritchard, 1835, 1842). The text is important, however, for being an early and detailed investigation of the law and psychiatry within the Scottish context. Moreover, Pagan's textbook was published contemporaneously with the institution of the McNaughton Rules, and is a good representative of some of the counterarguments in insanity pleas – particularly that cases should be decided less on the question of motivation and prior knowledge (as stipulated by the McNaughton Rules), than on simple evidence as to the presence or absence of insanity (Smith, 1990; Hunter & Macalpine, 1963, pp. 576-7, 595, 631-2, 637-8, 838, 841-2 & 974-5). His textbook also included much traditional material, exposing the proverbial tendency of criminals to counterfeit madness so as to avoid responsibility for their crimes. Illustrating this concern, he gives an account of how one man's reaction to having water thrown on him gave him away as feigning! Nevertheless, rather than from his own practice, Pagan gleaned most of his case material from other authors, and the book failed to enter into further editions or to be referred to in other standard works. Pagan was a prominent Glasgow physician and influential Director of Glasgow Royal Asylum, who referred a number of patients to the Asylum. He was later to become Professor of Midwifery at Glasgow University.

Mackintosh also professed an interest in this area in his Annual Reports, where he discussed infanticide and other forensic cases at some length (e.g. GAR, 1856, pp. 26-8). Disagreeing with many of his colleagues, he also denigrated the use of the expression 'criminal lunatic', asserting that someone is either one or the other and that it is misleading to label someone 'criminal' if they are insane (GAR, 1855, pp. 27-9). Such terminology, averred Mackintosh, 'degrades' the patient (*ibid*, p. 28). Despite such interests, however, Mackintosh made no other published use of his clinical material, regretting rather lamely that: 'in Scotland there is no proper medium for medico-legal and other investigations and papers on insanity than the ordinary periodicals' (GAR, 1854, p. 37).

W.T. Gairdner's impact on forensic psychiatry was rather more important. He lectured on medical jurisprudence and forensic psychiatry within his programme of lectures at the University and Royal Infirmary. His teaching on these matters appears to have had a profound impact on his former pupil, David Yellowlees (see *infra*). Alexander Robertson likewise lectured on forensic psychiatry in the courses on mental diseases he presented at the Town's Hospital and at St. Mungo's College. Both practitioners published worthy but rather conventional contributions to the field. More significantly, they agitated for the legal

admissibility in insanity trials of histories of heredity disorder and for the legal recognition of 'short suspensions of consciousness', as well as partial insanity – and therefore partial responsibility (e.g. Gairdner, 1873; Robertson, 1877c). It was partly this agenda that had led such clinicians, and others like Coats, to be preoccupied with cases of automatism and criminal acts provoked by epileptic seizures (e.g. Robertson, 1873; Coats, 1876).

It was Yellowlees' work in this field, however, which seems to have comprised the most significant contribution from Glasgow. His interest in forensic psychiatry had begun at Edinburgh and Glamorgan Asylums, and he published articles on the subject that, according to Clouston, were 'highly esteemed' at home and abroad (Yellowlees, 1862a; 1863a & 1863b, pp. 8, 13 and 16; Clouston, 1887, pp. 202-3). Yellowlees' investigation of forensic psychiatry continued at Gartnavel Royal, where he wrote on "the criminal responsibility of the insane" and on the insanity plea (Yellowlees, 1874, 1876a & b, 1877b, 1878, 1883). Yellowlees made a direct assault on the legal system, which he saw as considerably antithetical to the establishment of 'scientific' truth. He also criticised juridical emphasis in deliberating over the mental state of the accused on questions of 'habit and repute', and the presence of 'delusions' before a crime. Like Gairdner and Robertson, Yellowlees campaigned for primary weight to be given to whether mental disorder was dominant enough 'to control and determine' conduct. While also elaborating on Gairdner's views that, given the 'graduation of disease' there 'ought . . . to be some graduation of punishment' for insane criminals (Yellowlees, 1883; *Journal of Mental Science*, Oct., 1883, pp. 447-50), he seems to have leant further than some of his colleagues towards ascribing criminality (on similar grounds) to mental disturbance. Once again, taking Gairdner's lead, and as an alienist who placed more emphasis on hereditary predisposition than perhaps any other of his day, Yellowlees also strongly supported the legal acceptability of evidence of insanity in the family. Yet while all these practitioners may be seen as part of a general campaign to have 'expert' psychiatric testimony credited as being scientific, objective, and potentially conclusive, it is questionable whether their contributions alone amounted to anything truly unique within the discipline as a whole, or to what extent they were reciprocated by practical changes. It is also doubtful whether together they can be said to have made for a truly distinctive Glaswegian commentary on this subject, or be seen to have constituted a coherent group, with any thoroughly coordinated programme of aims.

Pathological Research

One area where Glasgow was possibly as successful as Edinburgh was in neuro-pathological research, although curiously, this does not appear to have involved much collaboration with the Royal Asylum. The work of Alexander Robertson in this field has already been mentioned, yet he was just one member of a closely-knit group of Glasgow clinicians who were energetic investigators of mental pathology. The activity of this group was focused in particular around the meetings of the Glasgow Medico-Chirurgical Society (especially its Clinical and Pathological Section), and articles published in the Society's journal, the *Glasgow Medical Journal*. Most amongst this group had either served as Presidents

or in other lesser offices, of the Society and/or one of its divisions, and some were one-time editors of the journal. Most were also members of Glasgow's Philosophical Society. They were generally specialist pathologists, or had been employed at one time in that field, and significantly tended to be more closely connected with the Glasgow Infirmaries than with the Royal or any other Glasgow asylum. The most prominent figure in this group apart from Robertson, was Joseph Coats, the first to be appointed to a pathology chair at the University. Coats (1846-99), whose career had begun as an assistant at the Argyll and Bute Asylum, contributed an impressive array of articles and case presentations in mental and neuropathology, including cerebral tumours and haemorrhage, epilepsy, and sclerosis of the brain (Coats, 1871a and b, 1873, 1875, 1876, 1877a & b, 1878a & b, 1879a, b, c & d, 1882a, 1887a, b & c, 1888a & b, 1891, 1892b & 1893). The group also included T. K. Monro, J. L. Steven, Donald Fraser, and James Finlayson. Monro, who was Pathologist to the Victoria Infirmary in Glasgow, wrote his graduation thesis under the title *Essays in neurology: historical and clinical*, publishing the part of the thesis on the degenerative diseases of the nervous system in the *Glasgow Medical Journal* (Monro, 1895). His engagement with mental pathology and neurology was to continue throughout his career (e.g. Monro, 1898). John Lindsay Steven, a one-time Pathologist at the Infirmary and Professor of Pathology at St. Mungo's College, published (amongst other things) articles on the neuro-pathology of syphilis and other aspects of mental pathology (Steven, 1893, 1896, 1897a & b). Donald Fraser, Medical Officer at Paisley Burgh (Riccartsbar) Asylum and Physician to Paisley Infirmary, was likewise to make a number of contributions to the study of brain disease and aphasia (1871, 1880, 1889, 1893a-c, 1897). The work of James Finlayson (1840-1906), latterly Physician and Lecturer on Clinical Medicine to Glasgow Western Infirmary, likewise embraced neurological disorders and abnormalities, especially aphasia, paralysis, and epilepsy (Finlayson, 1878, 1879, 1880, 1888, 1896). W. T. Gairdner was another important figure in this group, collaborating, for example, with Coats in publishing a popular book of *Lectures to Practitioners* (Coats, 1888c) and an article on dreams and delirium, contributing a piece on the physiognomy of the insane to Finlayson's *Clinical Manual* (Gairdner, 1878), and making his own independent presentations on aphasia, brain disease, and other neurological defects (Gairdner, 1866a & b, 1879b, 1887, 1889, 1900).

Much of the neurological work done by this group was conducted prior to the period when mental medicine was to be divided by tensions and competition between neurologists and psychiatrists. Yet the meetings of the Medico-Chirurgical Society and the activities of this group of clinicians, who regularly collaborated in their research work, clearly helped to forge a strong regional identity for mental pathological work in Glasgow and to establish and refine common research assumptions and methodologies. Like Robertson and Finlayson, most of this branch of the Glasgow School were keen proponents of localisation theories in mental pathology and neurology; psychological explanations for aphasia and other neurological symptoms are rarely encountered in their work. Indeed, scepticism as to localisation was the exception rather than the rule (e.g., *Glasgow Medical Journal*, xi, 1879, p. 78). The common methods employed by members of this group included newly popular techniques such as percussion of the cranium (Robertson, 1878a & b, 1879b, 1892d), ophthalmology (Coats, 1899), and what Gairdner, in reviewing Coats' and Middleton's work

on sclerosis, distinguished as 'exact methods of observation', such as 'modern physiological histology and physiological chemistry' (*Glasgow Medical Journal*, xi, 1879, p. 210). This research also helped to cement links across the disciplines of psychiatry and general medicine, but the major focus and impact of such work was in the areas of morbid anatomy and histology. This seems partly to have been a matter of genuine vocation (Coats, for example, had trained under Rindfleisch at Würzburg, studying pathological anatomy) and partly a result of the rather tardy and under-supported development of pathological research as a whole in Glasgow. Indeed, the inadequacy of laboratory facilities for such research in Glasgow suggests why (despite Coats also having studied experimental physiology and experimentation under Ludwig at Leipzig), the Glasgow School's contribution to experimental pathology remained so limited (*Glasgow Medical Journal*, xii, 1879, pp. 283-4; Coats, 1899; *Lancet*, July, 1894, p. 1-11). The belated establishment of a Pathology Chair at the University, partly due to jealousy from another department, was likewise seen as a 'reproach . . . on the Glasgow . . . School' (*Lancet*, July, 1894, p. 113; Coats, 1899: p. 116).

Much of this work in Glasgow paralleled activities in Edinburgh, where neuro-pathological research was similarly centred around the Edinburgh Medico-Chirurgical Society and the *Edinburgh Medical Journal*. However, whereas an active part was taken in such research in Edinburgh by Clouston and his assistants at the Morningside Asylum, by contrast, little part seems to have been taken in Glasgow by Yellowlees and his staff at the Royal Asylum. A case presentation by Oswald before the pathological section of the Glasgow Medical-Chirurgical Society was recognised by Coats as a rare event that required encouragement (Yellowlees, 1877b; Oswald, 1894). While the discipline was given a boost in Glasgow by the establishment in 1896 of the new Pathological Institute at the Western Infirmary (*Glasgow Medical Journal*, xlv, 1896, pp. 357-68), pathological research in Glasgow still seems to have fallen behind the standards set in other major centres, such as London, Preston, Wakefield, and Edinburgh (e.g. Todd & Ashworth, 1991). It was in Edinburgh once again that one of the most important Scottish contributions to neuro-pathology was made, with Argyll Robertson's 1860s work on tabes dorsalis (*Edinburgh Medical Journal*, Feb. 1869). There, too, a central base was provided for pathological work in Scotland, through the inauguration of the Laboratory of the Conjoint Scottish Asylums in 1897. The Director was William Ford Robertson, former Pathologist at the Royal Edinburgh Asylum, who was to write one of the earliest Scottish textbooks on pathology (Gartloch Asylum, 1897, 1905; *Journal of Mental Science*, 45, 1898, pp. 105 & 204-5; W.F. Robertson, 1900; Beveridge, 1991, p. 381).

Post-script: Into the Twentieth Century

It was not until 1909, during Landel Rose Oswald's superintendence at Glasgow Royal (1901-21), that a similar laboratory to that at Edinburgh – the Scottish Western Asylum Research Institute (SWARI) – was established on the Gartnavel site (Gartloch, 1905; Woodilee, 1905; Andrews & Smith, 1993, p. 66). Supported by a £200 donation and a rent-free house from that asylum, the SWARI, was financed by both Glasgow Royal and the district and other neighbouring asylums in the region. At its height, according to Oswald's obituarist, this Institute catered

for 'the needs of over 6,000 patients' (Glasgow Royal, 1928, p. 3). It combined clinical research with practical diagnosis, also producing samples of sera used in treatments. Apart from these laboratories, and the major contributions to research on morbid cerebral anatomy made by figures such as Bevan Lewis, the main inspiration for this great drive for laboratory-based pathological research was the discovery of the organism that caused syphilis (Andrews & Smith, 1993, p. 66). Therefore, much of the SWARI's early research was focused around the field of syphilitic serology, although the laboratory's ambition broadly embraced the pathological origins and development of all mental disorders. This research institute was re-christened the West of Scotland Neuro-Psychiatric Research Institute in 1932, but was not to survive the formation of the NHS. The establishment of such psychiatric clinics in Scotland from the early twentieth century seems to have furthered the sense of identity amongst psychiatrists in general, and the coherence of shared clinical methodologies – and this was an area in which Glasgow does appear to have taken a lead.

The psychiatric teaching programme at Glasgow University also reflected these developments. By 1917, Glasgow was the only University in Scotland having both an endowed lectureship in Mental Diseases (at St. Mungo's College) and an endowed scholarship in aetiological research into insanity (Burns, 1984).

Under Oswald too, Gartnavel Royal established the first psychiatric clinic attached to a general hospital in the West of Scotland, with the inauguration in 1908-1910 of the psychiatric out-patients clinic at Glasgow's Western Infirmary, to which Oswald himself was appointed the Consulting Physician (Andrews & Smith, p. 61). Indeed, the success of this venture was in marked contrast to the situation in Edinburgh, where calls for a psychiatric clinic dating back to the 1870s, and culminating in a concerted effort in 1902 by the city's most prominent psychiatrists, failed to convince the managers of the Edinburgh Royal Infirmary of the necessity (Beveridge, 1991, p. 381). Thus, while Edinburgh psychiatrists had to continue to rely on teaching at Morningside and the extramural clinic at Stirling, Glasgow asylums could call upon the services of a centrally based out-patients clinic.

Oswald also served on a Royal Commission to investigate the mental health of Glasgow's school children (Glasgow Royal Asylum, 1928). His energy as a psychiatrist helped earn him the accolades of becoming President of the Section for Neurology and Psychiatry of the BMA and of the West of Scotland Medical Association (a society whose creation is further evidence of a growing *esprit de corps* amongst medical men in Glasgow and the west). Despite these achievements, it was not until the 1920s and 30s, following the appointment of Oswald's deputy, David Kennedy Henderson as PS of Gartnavel, that a scientific community on a par with, if not surpassing that in Edinburgh, took shape in the Glasgow region. Oswald was better known, at both Gartloch and Gartnavel, for his more practical endeavours in the area of basic patient care than for his contributions to the scientific study of mental medicine. He was the prime mover in introducing female nurses into the male wards, and in ensuring that Gartloch was the first mental hospital to build a separate nurses' home. Moreover, despite his early promise as a scholar and his succeeding Yellowlees as Lecturer in Mental Diseases at Glasgow University in 1904, Oswald published scarcely anything of note. Apart from brief case presentations, his first and only major contribution to the *Glasgow Medical Journal* was an article on the side-effects of sulphonal, made

in his final year as assistant at Gartnavel, and highly indebted to the previous work of Priestley (Oswald, 1894, 1895). Oswald also opened an 1896 RMA discussion on 'the use of sedatives and hypnotics in the treatment of insanity' (Oswald, 1896). Yet even his obituarist conceded that 'it was a pity that he did not contribute more to medical literature', implying one reason for this, perhaps, when emphasising 'that his whole life was bound up in the institution' (Glasgow Royal, 1928). Another reason is suggested by Oswald's comment that: 'the best hypnotics and sedatives . . . were found in exercise, work, distraction of thoughts, amusement, and such-like' (Oswald, 1896, p. 807). This was also, however, a belief shared by Yellowlees, Gairdner, Urquhart and many others amongst his Scottish colleagues.

Oswald's successor, D. K. Henderson, became the most famous and successful psychiatrist associated with the Glasgow Royal Asylum – a figure who once more emphasises the links rather than the divisions between Edinburgh and Glasgow psychiatry. Although he worked at Gartnavel prior to 1921, Henderson's role was subservient to Oswald. When he finally took over as PS in 1921, Henderson had already published at least 16 articles out of the rich fruits of his clinical experience. He was to make radical changes at Gartnavel, with the implication that the hospital had lagged behind in its development. In part, Henderson was to continue and supplement Oswald's work at Glasgow Royal, building on the hospital's links with the Western Infirmary's clinic, and with general practitioners in Glasgow, and was to implement what Oswald had merely proposed in respect of a programme of mental hygiene (Henderson, 1923a, 1925b). Henderson and the other medical officers at Glasgow Royal were praised by the General Board of Control for the 'inter-clinics, held by the Medical Superintendent and his assistants . . . attended by Glasgow physicians', which were hailed as 'a special feature of the methods employed to extend the knowledge of mental diseases' (Annual Report 1926, General Board of Control). Henderson also worked closely with the Scottish Western Asylum's Research Institute (e.g. GAR, 1928, p. 8).

More importantly, he was to bring experience with him and implement in Glasgow some of the latest initiatives in psychiatric medicine, gleaned from his periods studying at the Johns Hopkins Clinic in Baltimore under Adolf Meyer, and at the New York State Psychiatric Institute. Meyer was the originator of the psycho-biological school of psychiatry, 'an attempt to blend neuroscience with the insights of the developing schools of psycho-analysis' (Andrews & Smith, 1993, pp. 73-4), and Henderson worked with him throughout 1908-11. Meyer's influence was to prove seminal in Henderson's approach to psychiatry and for Glasgow psychiatry as a whole. Henderson had also studied in Germany, at Munich, where he became closely associated with the work of Emil Kraepelin (attending his clinic on a post-graduate course in psychiatry) and Alois Alzheimer. He was to conduct research and publish on the subject of Alzheimer's Disease as early as 1913, and again whilst at Gartnavel (Henderson, 1930).

It was during Henderson's superintendence that many of the features of the modern psychiatric hospital were introduced to Gartnavel, including the establishment of Scotland's first separate Occupational Therapy Department, and the introduction of consulting staff to the asylum (including a dentist, pathologist, and psychologist) – initiatives that were to have considerable reverberations in similar developments at other Scottish asylums (Henderson,

1925a; GARs, 1921-31). Henderson inaugurated the most up-to-date practices in clinical case-note taking, with separate typed case files for each patient, and case conferences involving a range of medical staff. He also produced perhaps Glasgow's most famous and popular psychiatric textbook (Henderson, 1927), a work that, with the collaborated efforts of R. D. Gillespie and I. R. Batchelor, was to go into its tenth edition in 1969.

Connections forged by Henderson with Johns Hopkins benefited his trainees with patronage and education abroad, in an expanding, and increasingly cosmopolitan market for medical education and psychiatric posts. Some of Henderson's assistants, following in his footsteps, took six-month sabbatical courses at Johns Hopkins whilst at Gartnavel (*Annual Report of General Board of Control for Scotland*, 1926, p. xxi). These included both Angus MacNiven, who succeeded Henderson as PS in 1932, and T. Ferguson Rodgers (GARs, 1926, p. 16 & 1931, p. 16). Following Henderson's departure from Gartnavel in 1931, incentives to the young psychiatrists were furthered by the establishment of the Henderson Research Scholarship. As a committed 'mental hygienist', Henderson was also appreciative of the need to deal with mental disorder early in life. He and other Glasgow-based psychiatrists provided great support for the work of both the Notre Dame and the Craiglockhart Child Guidance Clinics (GAR, 1931, p. 22), while Henderson had written quite extensively on adolescent mental disorders himself.

On the other hand, there were considerable limits to his achievements and to the coherence of the Glasgow School of Psychiatry, even in this period. While the adoption of single case files and case conferences was to dominate the format of the psychiatric clinical encounter in Scotland for years to come, there were clear limits to the sense of community bred by this initiative. Transcripts of early case conferences at Gartnavel suggest considerable tensions and differences of opinion amongst the clinical staff, together with a tendency for the submergence of such conflicts under the pronouncements of the Superintendent (GGHB1, 1923, 3/5/1 78-94).

Throughout his superintendence, Henderson lobbied vigorously but unsuccessfully for the establishment of a special clinic for the early treatment of incipient, acute mental illness, and of the milder forms of mental disorders ('the neuroses and the psychoneuroses'). This was a subject first raised in the 110th Annual Report (1923, p. 19), where Henderson promoted it not only as a vital aspect of prophylactic psychiatry, but also as way of establishing closer links with general hospitals. In his 115th Annual Report (1928, p. 25), he advocated the establishment of a 100-150 bed psychiatric clinic in the community. In this, he had no doubt been influenced by Meyer, by initiatives in Germany, Austria, and the USA, by a growing awareness of the need to confront mental illness in the community (the 'mental hygiene' movement), by a burgeoning literature on the 'borderlands' of mental illness, and by the nascence in Glasgow and elsewhere of out-patient clinics. Henderson cited Meyer's 1912 article, 'Aims of a psychiatric clinic', in his Edinburgh Morison Lecture on 'Social Psychiatry' (Henderson, 1931). Henderson had visited the US again in 1929, to attend the opening of the New York Mental Hospital, and had returned with even more vigorous advocacy for the setting up of a clinic or Psychiatric Research Institute. He envisioned this very much on Meyerian lines, working in affiliation with a general hospital, and designed for the early detection, treatment, and prevention of mental illness,

as well as for research and teaching (GARs, 1929, pp. 20-23; 1930, p. 20). The declared ambitions of Henderson and other clinicians were: to persuade patients and families of the need for early treatment; to mitigate the stigma of committal to an asylum; to afford treatment to incipient and milder forms of mental illness, not adequately catered for within current psychiatric institutions; and, finally, to extend research and knowledge of the psychopathology and treatment of mental disorder.

Nevertheless, Henderson failed to persuade any benefactor to donate the funds required to set up such an institution (GAR, 1932, pp. 5-6), and left Gartnavel in 1931 to take up the more prestigious post of PS at Morningside and Lecturer in Psychiatry at Edinburgh University. Yet his ambitions were to be pursued and realised within a few years of his appointment by his protégé and successor as superintendent, Angus MacNiven. Nurtured like Henderson on the example of the Johns Hopkins Clinic, MacNiven was just as convinced of the need for 'a Psychiatric Clinic' or 'Treatment Centre' in Glasgow. In 1934, after a sustained campaign, the Lansdowne Clinic was inaugurated for the treatment of the psycho-neuroses, receiving 186 referrals within the first 8 months of its opening in 1935 (GARs, e.g. 1932, pp. 23-7; 1933, pp. 25-6; 1934, pp. 18-26; 1935, pp. 15-16 & 26-9).

Conclusions

The second city of the British empire was much praised for its Asylum during its early years by visitors to the city, e.g. for innovations in the publication of statistics and record keeping. This early promise does not, however, seem to have led to a cohesive and distinguished nineteenth-century school of psychiatry. The published output of the most renowned of Glasgow's psychiatrists during this first 100 or so years had a rather limited impact on the psychiatric world at large. Before the twentieth century, there was no major successful textbook from any of the Glasgow alienists. Differences of opinion amongst leading psychiatrists in the Glasgow School, on such fundamental issues as restraint were publicly expressed, with vigorous interchange, at MPA meetings. The Glasgow School also seems to have suffered from a tendency to disintegration at its early stages, with many trainees ceasing to specialise and gravitating to posts outside psychiatry. If, however, the achievements of the Glasgow School were modest by comparison with those of Edinburgh, there was also significant reciprocation in the background, activities, and output of both schools, so that any attempt to establish an unmitigated differentiation between them must be artificial.

On the other hand, at more specific levels, this comparison is revealing about the development of psychiatry in different centres during this period. Ultimately, the lack of coherence and prominence of the Glasgow School was not to change until the early twentieth century. Indeed, it was at this time that Gartnavel Royal in particular emerged as a rather more major force in a new era of Scottish psychiatry, encouraged especially by the innovations Henderson brought with him from Germany and the United States. This is not to say, however, that this fertile period prevailed in all spheres, or was to be fully sustained through MacNiven's period as PS. Despite, for example, the victory achieved in 1880 over resistance at the main medical school to the establishment of psychiatry

as a discipline worthy of study in its own right (rather than as a minor part of general medicine), during the subsequent century, the subject still seems to have struggled to assert its status within the university teaching programme. Psychiatry remains to this day a poor sister to general medicine within Glasgow University Medical School, with one of the smallest University Departments of Psychiatry serving one of the largest medical schools.

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For a more comprehensive exploration of the output of the Glasgow School, of which this paper represents only a partial summary, see ANDREWS, J., *A Failure to Flourish? David Yellowlees and the Glasgow School of Psychiatry*, forthcoming in *History of Psychiatry*.

17 On the Origins of Psychiatric Thought: the contribution of Edinburgh, 1730-1850

ALLAN BEVERIDGE

It has been the misfortune of most of those who have study'd the Philosophy of the Human Mind, that they have been little acquainted with the structure of the Human Body, and the laws of the Animal Oeconomy; and yet the Mind and Body are so intimately connected, and have such a mutual influence on one another, that the constitution of either, examined apart, can never be thoroughly understood. For the same reason it has been an unspeakable loss to Physicians, that they have been so generally inattentive to the peculiar laws of the Mind and their influence on the body. (Gregory, 1765)

The above passage was written by John Gregory, Professor of Physic at Edinburgh and previously occupant of the Chair of Philosophy at Aberdeen (Lawrence, 1984). Gregory sought to highlight the unhelpful division he saw existing in the study of mind and body. That divide forms a significant part of the intellectual landscape of this chapter which seeks to trace the development of ideas about the nature of mental disease as they evolved in Edinburgh from the eighteenth to the mid-nineteenth century. It will consider the writings of philosophers and physicians, but also take into account the views of the wider society. What we now call psychiatry grew out of a complex matrix of notions about madness derived from philosophy, religion, medicine, literature, and lay opinion (Rousseau, 1980; Bynum, 1983; Shepherd, 1983)

The chapter will concentrate on the 120-year span from the Scottish Enlightenment *litteratis'* attempt in the early 1700s to construct a philosophy of mind, to the rise and fall of phrenology in the middle of the nineteenth century. It was an astonishingly fertile period which saw the emergence of Edinburgh as the leading medical school in Europe, with its pioneering role in emphasising the importance of the nervous system as the prime supervisor of bodily function. It witnessed the fashionable interest in 'nervous' disease which Edinburgh alumni such as Cheyne and Whytt did much to popularise. It saw the first attempts to classify insanity in the work of Cullen, whose term 'neuroses' has survived to the present day, albeit in much different guise. A striking number of men, who later made a significant contribution to 'mental science', studied at Edinburgh medical school: men like Benjamin Rush, James Cowles Prichard, W.A.F Browne, and John Connolly. Innovative enquiries into the mysteries of the mind were conducted by Edinburgh professors such as

Dugald Stewart, Thomas Brown, and Sir William Hamilton, who all lectured on mesmerism, dreaming and the unconscious. The era also saw the removal of psychology from the province of philosophy and its relocation in the field of biology, as a result of the influence of Gall's phrenology – a doctrine which found its British champions in two Edinburgh brothers, George and Andrew Combe. In literature, the Edinburgh lawyer, James Boswell produced not only the *Life of Johnson*, one of the most highly regarded biographies in the English language, but he also left a revealing series of personal journals, which have subsequently struck a chord with a twentieth-century audience, preoccupied with the self and its travails. In imaginative literature, the period begins with Henry Mackenzie's hymn to exquisite sensibility, *The Man of Feeling*, and ends with James Hogg's dark parable of madness and religious fanaticism, *Confessions of a Justified Sinner*.

The era also witnessed the birth of psychiatrists and asylums. At the beginning of the period, there existed general physicians such as William Cullen and Robert Whytt who took an interest in mental disease; by the close, there were men like W.A.F. Browne and David Skae, who devoted their entire working career to the care of the insane. These nascent 'mad-doctors' also had a new location in which to work: the asylum. In Enlightenment Edinburgh, the mad had been catered for in the City Bedlam, bridewells, poorhouses and, if they were rich, private madhouses. By the mid-nineteenth century, they also had another potential refuge, the Morningside Asylum, which was just beginning to provide for pauper as well as private patients.

These changes reflected parallel developments throughout Europe and they have been the subject of great historical debate, as a result of the radical re-readings of the period by Foucault (1967) and Scull (1979, 1993), amongst others, who have challenged the conventional account of the gradual progress from the barbarism of the past to the humanity of the present. Instead, these revisionist writers see in the growth of the asylum the repressive response of a society troubled by signs of discontent and disaffection amongst its lower orders. In addition, Scull (1979) has viewed the emergence of asylum doctors as part of what he calls 'the medical capture of insanity', and discounts claims that the new profession was inspired by humanitarian motives. It is unnecessary to rehearse the details of this debate which has seen such radical views vigorously contested (Midelfort, 1980; Sedgwick, 1982; Porter, 1990; Grob, 1990; Berrios & Freeman, 1991). In any case, this chapter is more concerned with the history of ideas about madness than with institutional and professional developments.

Background

Between 1730 and 1850, the population of Edinburgh increased five-fold (Keir, 1966). At the beginning of this period, most of Edinburgh's citizens lived in tall, narrow buildings lining the High Street, which stretched along a volcanic ridge from the Castle to Holyrood House (Smout, 1969). All social classes lived in these tenements, with the well-to-do occupying the lower floors, and the poorer people at the top. During this period, a massive engineering and building programme brought about the creation of a second city to the north of the Old Town, and this led to a gradual migration by the wealthier classes to the more spacious and elegantly designed Georgian crescents and squares

of the New Town. The Old Town deteriorated, becoming even more cramped, dirty and unhealthy; the tenements crowded with poor families, their numbers swollen by Highlanders fleeing the Clearances and Irish people escaping from the potato famine in their native land (Smout, 1986; Hamish Fraser & Morris, 1990). By the mid-nineteenth century, Edinburgh was, in effect, two towns: the New Town which accommodated the well-heeled and prosperous, and the Old, which housed the poor and destitute.

Eighteenth Century

The Scottish Enlightenment

In the middle of the eighteenth century, an outburst of intellectual activity took place in Scotland which has come to be known as the Scottish Enlightenment, and which had enormous influence on both Europe and America (Bryson, 1945; Chitnis, 1976; Philipson, 1981; Campbell Skinner, 1982; Carpintero, 1982; Daiches, Jones & Jones, 1986; Christie, 1987; Calder, 1991; Allan, 1993). This period saw the seminal work of Adam Smith on economics, Adam Ferguson on sociology, Joseph Black on chemistry, James Hutton on geology, David Hume on philosophy and William Cullen on medicine. Although both Glasgow and Aberdeen made significant contributions, it was in Edinburgh that most of the activity took place. In his novel, *Humphry Clinker*, Tobias Smollett (1771) called the Scottish Capital 'a hotbed of genius', while an English visitor to the city reported: 'Here I stand at what is called the *Cross of Edinburgh*, and can, in a few minutes, take fifty men of genius and learning by the hand' (Smellie, 1800). The American, Thomas Jefferson proclaimed that, 'no place in the World can pretend to a competition with Edinburgh' (Cameron *et al.*, 1967).

At the core of the Scottish Enlightenment was the study of man himself – what Hume had called the 'Science of Man', founded on a desire to study scientifically the contents of the mind or, as contemporaries termed it, 'ideas or beliefs'. The study of man was regarded as the starting point for all the other sciences, and its general aim was the improvement of man's understanding of himself, both as an individual and as a social being. As Phillipson (1981) has observed, it was 'the first attempt to make a genuinely sociological study of man, society and history'. Before considering the development of medicine in Edinburgh, it is important to sketch the philosophical ideas of the Scottish Enlightenment which underpinned it; in particular, the attempts to study the mind, and the emphasis given to the ideas of sympathy and sensibility.

Philosophy of Mind

The Enlightenment philosophers were determined to do for the science of man and society what Bacon and Newton had done for matter. They believed that 'the philosophy of mind' or 'psychology' might achieve the status of some branches of natural philosophy (Bryson 1945; Robinson, 1961; Broadie, 1990). Human nature could be known as truly as other phenomena, and the workings of the mind could be studied using the empirical methods of Bacon and Newton, and the introspective techniques of Locke. By such methods, the general laws of the mind would be revealed. The subtitle of David Hume's (1739) *A Treatise of Human Nature* spelt out the ambition: 'Being an attempt to introduce the experimental

Method of Reasoning into Moral Subjects'. Hume aimed to become the Newton of the Human Mind.

As Lynch (1991) has observed, there are dangers in implying that there was a single core of Enlightened ideas because fundamental differences often existed between individual thinkers. For example, Hume, the *enfant terrible* of the *litterati*, assumed a sceptical and secular stance which treated scientific theories as the provisional fictions through which human beings tried to understand the world; and, alarmingly for some, he also did away with the notion of an Almighty. Hume provoked the 'Common Sense' school of Thomas Reid and his followers, which aimed to demonstrate that there was, in fact, an unshakeably secure ground for human knowledge in the beliefs common to all men, i.e. 'common sense'. Further, in contrast to Hume, they affirmed their belief in God and sought to reconcile religion and science. What united eighteenth-century Scottish thinkers was the belief that the mind could be studied and that the most suitable methods were those of introspection, observation, and induction.

Sympathy and Sensibility

In their account of man and society, Scottish thinkers consistently underplayed the importance of reason and, instead, emphasised the role of passions and emotions: from Francis Hutcheson onwards, they maintained that feelings were the basis of all human actions. Hume (1739) famously declared that, 'reason is, and ought only to be, the slave of the passions.' In such a philosophical schema, notions of sensibility and sympathy assumed great importance (Dwyer, 1987), Hume saw the principle of sympathy – man's capacity to feel for others – as the foundation upon which society was built, while Adam Smith (1966) used the same principle as the basis of his social and ethical philosophy in his *Theory of Moral Sentiments*. These notions of sympathy and sensibility found echoes in the medical theories of the Edinburgh physicians, as well as in the wider society: such notions provide a link between the discourses of philosophy, medicine, and the general public.

Edinburgh Medicine

A major aspect of the Scottish Enlightenment was the flourishing of medicine; between 1750 and 1800, Scottish universities educated almost 90% of all British medical graduates (Hamilton, 1981). Foremost amongst the Scottish medical schools was that of Edinburgh, which was founded in 1726, and became, by the second half of the eighteenth century the most successful in Europe (Comrie, 1927; Lawrence, 1984; Brunton, 1992; Rosner, 1991; Nicolson, 1993). In its teaching, the Edinburgh school embodied the principles of the Enlightenment: it stressed the social role of the scientist and aimed to expose the student to a wide range of the sciences. It had been inspired by the Dutch school at Leyden, whose most prominent professor, Hermann Boerhaave taught a physiology which pictured the body as a complicated hydraulic machine made up of fibres and fluids, of which blood was the most important. The Edinburgh school was to overturn this vascular model, and replace it by one based on the nervous system, which was held to be the supreme coordinator and communication channel for all bodily activity. Through the work of Robert Whytt, Alexander Monro *secundus*, John Gregory, and William Cullen, Edinburgh became in Porter's (1987) apt words, 'that great "nerve centre" of Enlightenment medical education'.

The physician who initiated the shift from orthodox Boerhaavianism to the physiology of the nervous system was Robert Whytt, who became Professor of the Institutes of Medicine in 1747. Whytt is best remembered as the first physician to describe reflex action and to show that the brain was not necessary for its occurrence (French, 1969; Spillane, 1981; Bynum, 1985; Clarke & Jacyna, 1987; Moore, 1993). In many ways, he was the most important of Edinburgh's eighteenth-century professors. Indeed, Lawrence (1984) has described Whytt's move from vascular to nervous physiology as 'one of the most significant shifts in the intellectual history of medicine'; in comparison, the work of Whytt's successors in the Edinburgh chair was little more than elaboration and variation on his original doctrine.

Whytt (1751) believed that human beings had a soul, and were not 'mere inanimate machines'. In opposition to the mechanical models of man then prevalent, he argued that humans showed purpose in their behaviour, and held that man possessed an immaterial substance which he called, 'the sentient principle'. This acted as the co-ordinator of the operations of the nervous system and, by extension, the whole body. Whytt maintained that nervous activity was integrated by the mechanism of 'sympathy', a term he used to describe the communication of nerves with different parts of the body. He drew on Lockean psychology, which held that 'sensations' were the basis of all thoughts, to explain how the nervous system communicated with the outside world. The nerves received stimuli from the external environment, which they then transmitted in the form of 'sensations' to the mind. The 'sensibility' of nerves varied with their physical state, and thus the quality of sensations experienced by the mind varied. In Whytt's nervous physiology, an individual's 'sensibility' was a function both of the quality of his nerves and of the nature of his environment.

Whytt's neurophysiological theory had obvious implications for the understanding of nervous disease: if an individual's nerves were impaired or if his environment was hostile, then nervous symptoms could well ensue. In 1765, he outlined his views in *Observations on the Nature, Causes, and Cure of those Diseases which are Commonly Called Nervous, Hypochondriac or Hysteric*. He contended that:

All diseases may, in some sense, be called affections of the nervous system, because, in almost every disease, the nerves are more or less hurt; and, in consequence of this, various sensations, motions, and changes, are produced in the body. However, those disorders may, peculiarly, deserve the name of nervous, which, on account of an unusual delicacy, or unnatural state of the nerves, are produced by causes, which, in people of sound constitution, would either have no such effects, or at least in a much less degree. (Whytt, 1765)

Whytt divided the sufferers into three classes. Firstly, there were the 'simply nervous', who were in good health but whose 'uncommon delicacy' of nerves rendered them liable to tremors, palpitations, faintings, or even fits if the emotional upset was severe enough. Secondly, were those described as 'hysteric', who were similar to the first group, but in addition were prone to bowel complaints such as indigestion, flatulence, and 'a sense of cold in the back part'. Lastly, were those described as hypochondriac, who were not only plagued with indigestion, belching, and flatulence, but were also afflicted with 'low spirits, disagreeable thoughts, watching or disturbed sleep'. Whytt's work played a significant role

in the wider popular preoccupation with 'nerves' which characterised the later eighteenth century.

Whytt's successors – John Gregory, Alexander Monro *secundus*, and William Cullen – incorporated much of his thinking, especially the prime role given to the nervous system. Of these three, Cullen is by far the most famous, but it is worth noting that Monro made a contribution to the understanding of the anatomy and physiology of the nervous system, while Gregory helped his cousin, Thomas Reid develop the philosophy of Common Sense.

William Cullen occupies an important place in the history of medicine and psychiatry (Thomson, 1859). However, as has recently been emphasised (Doig *et al.*, 1993), he made no discoveries, he developed no new remedies, his work on the nervous system has been judged less original than that of Whytt, and his attempts at nosology have been damned as misguided and useless. What then, if anything, is left of Cullen's legacy, especially with regard to psychiatry?

Firstly, Cullen's views on insanity were enormously influential in Europe and America. His ideas were taken up by Phillippe Pinel, whose first medical publication was a translation into French of Cullen's textbook. Vincenzo Chiarugi, the leading Italian alienist hailed Cullen as 'the one who has brought most light to this obscure subject'. His work also influenced physicians in Germany, Austria, and Denmark (López Piñero, 1983). Secondly, Cullen taught an impressive array of pupils, whose work made a significant contribution to ideas about nervous and mental diseases, amongst them Thomas Arnold, John Brown, Alexander Crichton, John Ferriar, William Hallaran, Thomas Trotter, and Benjamin Rush, who brought his theories to the New World (Hunter & Macalpine, 1963; Porter, 1988a, 1988b).

The reasons for Cullen's influence lie in his pioneering discussions of insanity. The fourth edition of his *First lines in the practice of physic*, published in 1784, was one of the first medical textbooks to give an account of insanity, while his *Nosology* (1800) contained an early attempt to classify the various types of insanity, and was extensively used by later writers to understand nervous complaints (Bynum, 1993a).

Cullen introduced the term, 'neurosis' into the language, although, as numerous commentators have observed, the term has changed radically over the last two hundred years from his original definition. In fact as Bynum (1993b) has pointed out, Cullen's 'neuroses' embraced a wide range of disorders, only some of which would be considered psychiatric by today's understanding. Cullen (1784) defined the neuroses as:

all those preternatural affections of sense and motion, which are without pyrexia as a part of the primary disease: and all those which do not depend upon a topical affection of the organs, but upon a more general affection of the nervous system and of those powers of the system upon which sense and motion more specially depend.

A key subdivision was that of the 'Vesaniae' or insanities. By the addition of this group, Cullen expanded on Whytt's categories of nervous diseases, which had not included insanity. He believed that insanity was primarily a disease of the faculty of judgment, and in this, he followed John Locke, who held that madmen associated ideas incorrectly. Cullen maintained that the faulty associations of

ideas led to disrupted judgment, and considered that the underlying cause for this lay in brain malfunction. On the basis of this Lockean model of mental operations, Cullen speculated as to how the symptoms of insanity arose. He proposed that nervous symptoms could be explained by assuming that different parts of the brain were simultaneously in unequal states of 'excitement' and 'collapse': 'our reasoning or intellectual operations always require the orderly and exact recollection or memory of associated ideas; so, if any part of the brain is not excited, or not excitable, that recollection cannot properly take place, while at the same time other parts of the brain, more excited and excitable, may give false perceptions, associations and judgments' (Cullen, 1784).

Brown (1993) has stated that Cullen's crucial contribution was to define insanity as a mental disorder and to relate this to a dynamic neurophysiology. In general, eighteenth-century Edinburgh medicine can be characterised by its belief in the nervous system as the prime co-ordinator of bodily activity. Striking parallels can be seen between the language of clinicians and that of Enlightenment thinkers: just as physicians viewed the body as an integrated nervous system, dependent on the sensibility of its individual nerves for its efficient working, so philosophers saw the body politic as an integrated system dependent on the feelings of its individual members for its smooth running (Lawrence, 1979; 1984). Such medical and philosophical notions had resonances with the wider society.

The Age of Nerves

The eighteenth century was an age when the incidence of nervous disease was perceived to be increasing alarmingly (Porter, 1987). Such an increase in mental distress was regarded by many as the price paid for living in an advanced civilisation. Nervous afflictions seemed to particularly strike the affluent classes, and suffering from 'nerves' became very fashionable amongst the rich and well-to-do. The interplay between medicine and society is illustrated in a much-quoted observation by an Edinburgh medical graduate, James Mattrick Adair in 1786:

Upwards of thirty years ago, a treatise on nervous diseases was published by my quondam learned and ingenious preceptor, Dr. Whytt, professor of physick, at Edinburgh. Before the publication of this book, people of fashion had not the least idea that they had nerves; but a fashionable apothecary of my acquaintance, having cast his eye over the book, and having been often puzzled by the enquiries of his patients concerning the nature and causes of their complaints, derived from thence a hint, by which he readily cut the Gordian knot – '*Madam, you are nervous*'; the solution was quite satisfactory, the term became fashionable, and spleen, vapours, and hyp, were forgotten. (Adair, 1786)

In fact, Whytt's book was only one of many medical treatises about nervous disorders that appeared during the eighteenth century. The most famous and influential was by another Edinburgh-trained doctor, George Cheyne (Guerrini, 1989; Shuttleton, 1992) who, in 1733 published, *The English Malady: or, A Treatise of Nervous Diseases of all Kinds, as Spleen, Vapours, Lowness of Spirits, Hypochondriacal and Hysterical Distempers*. It became fashionable amongst the rich and well-connected during the eighteenth century to suffer from 'nerves'

because it was seen as a mark of social distinction, an attribute that separated the wealthy from the lower orders (Porter, 1987; 1991). Cheyne (1773) reinforced the social hierarchical nature of nervous disease, advising that, '*Fools, weak or stupid Persons, heavy and dull souls, are seldom much troubled with Vapours or Lowness of Spirits*'. Rather, it affected the well-to-do, whose nerves were so much more refined than the rude, unsophisticated plebeians. The causes of the malady lay in excess, whether of food, alcohol, or sex; and the remedy lay in moderation. Cheyne's book contained an account of his own nervous affliction, brought on by immoderate conviviality amongst the 'bottle-companions' of London, and it told of his eventual recovery by means of temperance and a milk and vegetable diet.

Cheyne's book was highly influential in the Georgian age, and his advice was taken up by a variety of eighteenth-century luminaries, such as Samuel Johnson, John Wesley, Samuel Richardson, and David Hume. Nervous diseases, of course, afflicted the *beau monde* of Edinburgh. Eighteenth-century Edinburgh society was extraordinarily compact: the literati, the doctors, and lawyers all knew each other, and met in the clubs and taverns of the city (Graham, 1908). This greatly increased the exchange of ideas, and it accounts, in part, for the striking similarity in language between physicians, philosophers, and ordinary citizens. Whytt was friendly with the capital's leading thinkers, and Cullen was not only on good terms with David Hume and Adam Smith, but advised the latter about his nervous disorder (Barfoot, 1991). As a young man, Hume himself had suffered from a bout of melancholy which he described eloquently in a letter to Dr. Cheyne (Greig, 1932).

Notions of sympathy and sensibility diffused throughout society in the capital, and, it was, after all, an Edinburgh writer, Henry Mackenzie (1771) who was responsible for the hugely popular novel, *The Man of Feeling*, which reflected the era's elevation of sentiment to a supreme virtue (Todd, 1986). The most vivid account we have of an Edinburgh citizen's nervous problems is that left by James Boswell (Pottle, 1966; Brady, 1984), who kept a journal in which he aimed to record the history of his mind (Pottle, 1950). Boswell's journal documents in startlingly candid terms the wild vicissitudes of his spirits: from exuberant self-advertising and unsolicited visits to Voltaire and Rousseau, to solitary episodes of suicidal despair; from discussions of morality with Dr. Johnson to amorous adventures with prostitutes on the Edinburgh Meadows; and from solemn vows of abstinence to alcoholic excess. As he confessed, he was either above life or it was above him. Boswell also wrote a magazine column entitled *The Hypochondriac* (Bailey, 1951), in which he described his battles with low spirits and gloom (Ingram, 1982). The remedy for mental suffering, as Dr. Johnson, an admirer of Cheyne's book, kept reminding him, was moderation (Boswell, 1791; Porter, 1985). It was advice that Boswell found impossible to follow, but his attempts, which he recorded so comprehensively and so candidly, provide a fascinating insight into the inner world of an individual in the age of sensibility.

Whilst nervous diseases enjoyed a fashionable vogue amongst the upper classes, popular discourse made a crucial and fundamental distinction between being merely nervous, which could be seen as an admirable state, and being mad, which was not. The Glasgow doctor-turned-novelist, Tobias Smollett, who took an interest in madness and who was himself troubled with melancholia (Rousseau, 1982), caught this distinction in his novel, *Sir Launcelot Greaves*.

'Doctor, (said our hero) if it is not an improper question to ask, I should be glad to know your opinion of my disorder – 'O! sir, as to that – (replied the physician) your disorder is a kind of a – sir, 'tis very common in this country – a sort of a –' 'Do you think my distemper is madness doctor?' – 'O Lord! sir, not absolute madness – no – not madness – you have heard no doubt, of what is called a weakness of the nerves, sir.' (Smollett, 1762)

We catch a glimpse of the actual mad people of the capital in the work of the local artist, John Kay, who produced hundreds of etchings of the characters of the city – the physicians, philosophers, lawyers, soldiers, actors, shopkeepers, and tradesmen (Kay, 1842; Evans & Evans, 1980). In Kay's skilfully recreated social panorama of Enlightenment Edinburgh are also to be found a handful of crazy citizens: such as James Robertson, 'the Daft Highland Laird', who wished to be executed as a Jacobite martyr, and who paraded through the streets with his wood-carvings of the public figures of the day; or John Skene, a flax-dresser who believed he held the exalted posts of Superintendent of the Court of Session and the General Assembly; and Mary Walker who repeatedly attended Parliament House in the belief she was due a large sum of money. In Kay's work, the mad are portrayed with benign tolerance, but they are also seen as mild figures of fun.

An event in Edinburgh towards the end of the eighteenth century revealed mental derangement in a more sombre light, and it also highlighted the distinction between suffering from mere 'nerves' and being mad. In 1774, Edinburgh's poet laureate, Robert Fergusson was suddenly afflicted with 'furious insanity' (Duncan, 1818; Beveridge, 1990). Fergusson's disorder was quite distinct from the socially acceptable condition of 'weakness of the nerves', as his friend and first biographer, Thomas Sommers (1803) clearly described: 'His brain being so disordered, he became so furious, that three men could hardly restrain his violence'. The only provision available for Fergusson, whose means were slender, was the City Bedlam. For the rich such as Boswell's brother, John, there were private madhouses and personal physicians (Ryskamp & Pottle, 1963). Fergusson's plight and his eventual death in the Bedlam two months after his admission exposed the lack of facilities in the capital for the mentally disturbed of the poorer classes. It inspired Dr Andrew Duncan (1792, 1803), who had visited Fergusson during his illness, to campaign for an asylum to be erected in Edinburgh; however, it was to take until the early part of the next century before this was done. The fate of Fergusson and the local perception of insanity should be seen as part of more widespread changes in society's attitudes to the mad and their care – changes which found their dramatic focus in the madness of George III. The King's illness demonstrated that even the highest in the land could be afflicted with lunacy, and Macalpine & Hunter (1969) have suggested that as a consequence, the popular view of insanity as a state of degradation gradually altered. The fortunes of 'mad-doctors' also improved when it was seen that the King seemed to get better as a result of their ministrations, although the Monarch probably recovered in spite of their attentions rather than because of them. The period also saw the birth of the asylum, symbolised by the opening in 1796 of the York Retreat, an institution which came to be perceived by contemporaries as a model of enlightened and humane care (Edinburgh Review, 1814; Digby, 1985).

Nineteenth Century

The Edinburgh Asylum

Andrew Duncan's wish for an asylum to be built in the Capital was not realised until nearly 40 years after Fergusson's death. Duncan was to play a significant role in this campaign, and in 1790, when he became Professor of the Institutions of Medicine, one of his first actions was to agitate for the erection of a public lunatic asylum. In 1792, he drew up 'A Proposal for Establishing a Lunatic Asylum in the Neighbourhood of the City of Edinburgh' which met with the approval of both the Colleges of Physicians and Surgeons, and which called for subscriptions from the local citizens. The response was but a trickle and, by 1806, barely over £100 had been raised. However, funds emerged from a rather unexpected source. The Government had obtained money from the forfeited estates of those clans who had fought on the side of the Jacobites in the 1745 Rebellion, and in 1806, it voted to give £2,000 of this sum towards the erection of the Edinburgh Asylum (Duncan, 1812; Mitchell, 1882)

It may be felt that the source of this money has a certain irony: a radical, revisionist interpretation would perhaps suggest that the spoils gained from crushing one rebellion were to be used by the victors to incarcerate the potential perpetrators of a future revolt. A student of Scottish cultural history might note that while the inhabitants of the Georgian drawing rooms of Edinburgh were celebrating an ersatz version of the Highlands as portrayed by Sir Walter Scott, the actual Highlanders were being systematically routed and their wealth, such as it was, appropriated for the benefit of Lowlands society. Nevertheless, the money did prove useful, and although it did not meet the full cost of the new building, eventually, after further appeals for funds, the Edinburgh Asylum opened its doors in 1813. Duncan (1812) had taken as his model for the new asylum the York Retreat which he had previously visited. He asserted that, 'the Retreat at York is at this moment the best regulated establishment in Europe, either for the recovery of the insane, or their comfort, where they are in an incurable state.' The Edinburgh Asylum was to adopt the Retreat's style of humane management and 'chains, stripes, and every rough mode of treatment' were to be 'completely banished'. The design of the new asylum was considered to be of great importance and a leading Edinburgh architect, Robert Reid was appointed for the task. Reid (1812) visited several asylums in England, including the York Retreat, and outlined his plans in *Observations on the Structure of Hospitals for the Treatment of Lunatics*. Markus (1988) has detected the influence of the Scottish Enlightenment's preoccupation with order in Reid's design, based as it was on the classification of patients by gender, income, and diagnosis, and he contrasts this rule-governed, Classical architecture of reason with the chaotic world of unreason that it sought to enclose.

The first decades of the Edinburgh Asylum were undistinguished, and marked by repeated protests that it was not fulfilling its remit to provide for pauper lunatics, though it did begin to admit such patients from 1837 onwards (Mitchell, 1882). The institution was originally run by lay staff, but in 1839, the managers appointed Dr William McKinnon as the first medical superintendent. His annual reports indicate that he favoured a form of moral management which relied on providing the inmates with occupation, opportunity to attend church service, and amusements such as reading, music, bowls, and country walks (McKinnon, 1840)

McKinnon retired early through ill-health, and was succeeded in 1849 by David Skae (Beveridge, 1991a).

Medical Writing on Mental Disease

The turn of the century and the early 1800s in Britain saw a great increase in the number of medical publications on insanity. A large proportion of these were by Edinburgh graduates: for example, Alexander Crichton's (1798), *An inquiry into the nature and origin of mental derangement*, in which he tried to analyse the mind using the principles of Thomas Reid; Thomas Beddoes' (1803), *Hygeia*, in which he discussed nervous disease and psychology; Thomas Trotter's (1804), *An Essay, Medical, Philosophical and Chemical on Drunkenness and its Effects on the Human Body*, which was the first book length analysis of drunkenness by a British doctor, and which stated firmly that drunkenness was a disease, more specifically a 'disease of the mind'; Joseph Mason Cox's (1806) *Practical Observations on Insanity*, describing his notorious swinging chair treatment; Thomas Trotter's (1807) later work, *A View of the Nervous Temperament*, which updated Cheyne's *English Malady* and dilated on the diseases of civilization; Benjamin Rush's (1812), *Medical Enquiries and Observations, upon the Diseases of the Mind*, which argued that insanity was caused by disease in the blood vessels of the brain; John Ferriar's (1813) *An Essay towards a Theory of Apparitions*, in which he discussed the phenomenon of 'spectral impressions' and affirmed that they resulted from a 'morbid disposition of the brain'; William Hallaran's (1818) *Practical Observations on the Causes and Cures of Insanity*, in which he distinguished between 'mental insanity' and that due to 'organic disease'; and, finally, W.A.F Browne's (1837) *What Asylums Were, Are, and Ought to Be*, a book which was to play a seminal role in the nineteenth-century development of the asylum (Scull, 1991). In this chapter, we are mainly concerned with those physicians who worked in Edinburgh or who, as in the case of Alexander Morison, were particularly associated with events in the Capital.

Morison currently enjoys a rather curious reputation. Although recognised for instituting the first formal lectures on mental disease in Britain and introducing one of the first psychiatric textbooks, he has nevertheless been damned as an unoriginal thinker and, worse, as a Scotsman on the make who exploited the field of lunacy for his own personal advancement (Macalpine & Hunter, 1969; Scull, 1993). However, his career has recently been re-examined by Hervey (1994), who provides a more sympathetic account, suggesting that Morison may have been side-lined by his contemporaries because he did not adopt the prevailing nineteenth-century institutional response to the insane, preferring to treat them 'outside Asylum walls'.

Morison had trained under Andrew Duncan, was on good terms with Alexander Crichton, and in 1818 had travelled to Paris to visit Esquirol. He later tried to have a chair of mental diseases created in Edinburgh with himself as its first incumbent, but was unsuccessful (Robertson, 1928). Undeterred by the failure of this venture, Morison began his lectures on mental disease in 1823, and presented an annual course of talks in Edinburgh and London for the next 30 years. Out of these grew his *Outlines of Lectures on Mental Diseases*, which appeared in 1825 and ran to five additions (Morison, 1825). In 1828, Morison published *Cases of Mental Disease*, which was intended to provide clinical case vignettes for students. He believed that in 'every case where the mind is disordered,

it is now generally admitted, that its organ, the brain, is either primarily or secondarily affected' (Morison, 1828). Morison favoured the approach of Pinel and Esquirol, which, he wrote, was 'founded on the morbid manifestations of the mental functions'.

Morison's interest in physiognomy was fired by his visits to Paris, where Esquirol had shown him his collection of 200 plaster-of-Paris casts of the faces of the insane and the drawings of patients that Theodore Gericault had completed (Hervey, 1994). The second edition of Morison's *Outlines of Lectures on Mental Diseases* contained 13 engravings based on Esquirol's collection (Gilman, 1982). By 1840, Morison had enough of his own material to produce *The Physiognomy of Mental Diseases*, which contained 108 plates of insane patients, and attempted to relate particular facial appearances to specific types of insanity. As he wrote:

The appearance of the face is intimately connected with and dependant upon the state of the mind; the repetition of the same ideas and emotions, and the consequent repetition of the same movements of the muscles of the eyes and of the face give a peculiar expression, which, in the insane state, is a combination of wildness, abstraction, or vacancy, and of those ideas and emotions characterising different varieties of mental disorder, as pride, anger, suspicion, mirth, love, fear, grief, &c. (Morison, 1840)

Morison's book was to prove very influential in both Britain and Germany (Gilman, 1982; Donnelly, 1983; Browne, 1985). His own physiognomy was itself the subject of study in the intriguing portrait by Richard Dadd, the celebrated Victorian painter (Smailes, 1980; Macgregor, 1989). By a fine stroke of irony, Dadd was, as is well known, a long-term inmate of Bethlem Asylum, and thus his painting of Morison may be considered to have reversed the direction of the 'psychiatric gaze'.

Another Edinburgh graduate, Sir Charles Bell (1806) also produced a guide to physiognomy, *The Anatomy of Expression*, which he illustrated himself. Bell sought to 'lay the foundation for studying the influence of the mind upon the body'. Most of the book was completed in Edinburgh (Comrie, 1927), apart from the illustration of 'Madness' which Bell drew after a visit to Bethlem Hospital in London. Bell saw madness as a state akin to brute animality, and claimed, like Hogarth before him, that he was guided by the 'moral aim, to show the consequence of vice and the indulgence of passion' (Gilman, 1982; Browne, 1985).

Less well-known and administering to a considerably poorer clientele than Morison was Richard Poole, the Manager to the Edinburgh Charity Workhouse and Bedlam, and later successor to W.A.F. Browne at the Montrose Asylum (Pitman, 1988). Poole is a rather neglected figure of early nineteenth-century lunacy, but he did much to improve the provision of pauper patients in the Capital, and his writing reveals that he was a widely-read and cultured man. In fact, Poole was something of a polymath. He contributed to the *Encyclopedia Edinensis*, writing 700 double-column quarto pages, on such subjects as mind, philosophy, language, and beauty. He also wrote poems, a play, a religious piece entitled *The Grand Contrast, God & Man* and a history of Montrose Asylum (Walmsley, 1991).

In 1834, Poole sent a letter to the President of the Royal College of Physicians

in Edinburgh, pointing out the lack of adequate provision for the city's pauper lunatics, despite the existence of the asylum at Morningside, founded to care for both rich and poor (Craig, 1976). As a result of Poole's intervention, the managers of the Morningside Asylum eventually agreed to admit paupers as well as fee-paying patients.

Poole had originally hoped to present a series of lectures in Edinburgh on mental disease, but he was anticipated by Morison. He did, however, write the first article on mental diseases to appear in the *Encyclopaedia Britannica*. In the 1842 7th Edition, Poole provided a ten-page entry which ranged over the writings of Plato, Hippocrates, Celsus, Galen, Willis, Stahl, Cullen, Pinel, Esquirol, Heinroth, Prichard, Charles Bell, and Marshall Hall, as well as referring to the Bible and Hebrew literature. Despite his erudition, he admitted that the definition of insanity was difficult, and rather apologetically, suggested the following: 'deviations from sound health, involving some of the functions of mind'. Likewise, in the classification of mental disease, Poole admitted existing nosologies were deeply flawed and mutually contradictory. He considered that treatment was still in its infancy, but strongly recommended the benefits of admission to an asylum. Poole concluded by reviewing lunacy legislation in Britain, and made use of the opportunity to highlight the lack of provision for pauper lunatics in his native land and in Edinburgh particularly:

Scotland, educated, and enlightened as she pretends to be, and with some justice, is disgraced by the absence of national or provincial asylums for these unfortunates . . . the metropolis is actually inferior to many of the provincial towns. (Poole, 1842)

The entry in the 'Encyclopaedia' reveals that in his approach to mind and body, Poole was a dualist: he maintained that the 'operations of the mind . . . are only manifested . . . in its material associate'. He believed that there was a 'vital force' or 'sentient substance', originating in the nervous system, which governed the body but whose nature was not discernible to human beings. Poole's thinking on this question is close to Robert Whytt's, although he did not specifically mention him in his article.

In 1830, another Edinburgh doctor, John Abercrombie published *Inquiries Concerning the Intellectual Powers and the Investigation of Truth*, in which he attempted to apply mental philosophy to the study of the mind. Abercrombie was an eminent consulting doctor who was appointed First Scottish Physician to the King in 1828 (Pitman, 1991). He had originally intended to join the ministry, but a bad stammer, which he did not overcome until later years, prevented him. Nevertheless, he remained devout throughout his life, writing religious tracts and also *The Philosophy of Moral Feeling* in which he outlined his sense of moral duty to God. Abercrombie's *Inquiries* followed in the tradition of the Edinburgh philosophers of mind, with its emphasis on observation and induction. He believed that the brain could be diseased without affecting mental processes, and that the mind could be deranged without any corresponding disorder being apparent in the brain. Like Poole, he was a dualist, believing in the existence of a separate entity called 'mind' which interacted with the world through the medium of the brain.

In the *Inquiries*, Abercrombie devoted a chapter to the subject of insanity,

which he compared to dreaming. He maintained that in both states, false ideas or images arose, over which the individual had no control. He also refuted the Lockean notion that the madman reasoned correctly from unsound premises, arguing instead that reasoning could often be illogical too. He sought to explain the genesis of these false ideas, and advanced five factors. They could be due to quirks of personality, old memories, day-dreams, physical sensations, or the feeling of being influenced by outside forces such as supernatural powers, electricity, or magnetism.

Abercrombie also discussed what he called 'spectral illusions', defined as 'false perceptions, or impressions made upon the senses only, in which the mind does not participate.' He gave numerous clinical vignettes, which caught the imagination of his readers who sent him further examples that were used in later editions of the book. Abercrombie's cases included: an elderly man who had been visited daily for the previous 12 years by a parade of 'spectral figures', dressed in costumes from France, Ancient Rome, Greece and the Scottish Highlands; a woman pursued by a little old lady with a red cloak and a crutch; a man who saw his deceased friend in his courtyard; a servant girl who saw a phrenological cast of a man's head come to life; an alcoholic patient who saw fairies dance in his room; a lady who saw the figure of death; and a gentleman plagued with spectral figures all his life who, when he met a friend in the street, was not immediately sure if the friend was real or just an apparition.

Abercrombie's book was generally well received, running to several editions, although some critics complained that he took no account of the influence of the brain on the mind. Abercrombie, for his part, noted that although attempts had been made to find a physical basis for insanity, little evidence of this had been found. In contrast to the large number of books about insanity published during this period, very few papers were written. Indeed, in the leading Scottish clinical publication of this time, *The Edinburgh Medical & Surgical Journal*, the main forum for discussing ideas about insanity was in the reviews of medical books on the subject.

Philosophical Writings

The study of the philosophy of mind, which the Enlightenment *literati* had initiated, continued into the nineteenth century through the work of Dugald Stewart, Thomas Brown, and Sir William Hamilton, who all occupied chairs of philosophy at Edinburgh University, and who all made an important contribution to the development of psychology (Murphy, 1929; Flugel, 1933; Peters, 1953; Klein, 1970; Robinson, 1986; Hearnshaw, 1987; and Berrios, 1988). These three philosophers can be seen as following in the tradition of the 'Common Sense' school, whose founder, Thomas Reid had outlined a type of Faculty psychology which opposed the Associationist view of the human mind as a *tabula rasa* evolving in response to the impact of experience (Albrecht, 1970; Brooks, 1976). Instead, Reid argued that man possessed innate capacities or 'faculties'. Reid's followers at Edinburgh brought about a reconciliation of these two opposing theories by incorporating certain tenets of Associationism into Faculty psychology; in essence, they gave the process of mental association the status of a special faculty of mind (Hoeldtke, 1967).

The first of these three Edinburgh philosophers was Dugald Stewart, who held the chair of moral philosophy from 1785 to 1820 and he is thus a transitional figure between the last days of the Scottish Enlightenment and the early nineteenth century (Robinson, 1961). Stewart delivered inspiring lectures which Henry Cockburn (1856) described in his *Memorials* as 'like the opening of the heavens' and which elevated the listener into a 'higher world'. However, even Cockburn concedes that Stewart was not an original thinker. Nevertheless, his interest in abnormal psychology did influence contemporary medical approaches to insanity, and his lectures were attended by Alexander Crichton (Weiner, 1990), John Conolly (Scull, 1985), and James Cowles Prichard whose description of 'Moral Insanity' was said to have been influenced by the Edinburgh's professor's account of the moral sense (Chitnis, 1986). In his *Elements of the Philosophy of the Human Mind*, Stewart discussed aspects of abnormal psychology such as his theory that insanity and dreaming bore a certain similarity (Hamilton, 1854). In a manner similar to Abercrombie, whom he anticipated, Stewart argued that just as the dreamer accepted the reality of the events and characters in a dream because sleep had suspended his judgment, so the madman too believed in the reality of his visions and delusions, because his judgment had also been impaired.

Drawing on Enlightenment notions of the importance of feeling, Stewart described 'sympathetic imitation', by which he meant the capacity of individuals to respond to and be influenced by another's emotional state. In this context, he examined the 'contagious nature of convulsions, of hysteric disorders, of panics', and the psychology of crowds. He also suggested that certain kinds of insanity could be spread by emotional means. Stewart took a particular interest in mesmerism and maintained that the study of this subject provided 'inestimable data for extending our knowledge of the laws which regulate the connection between the human mind and our bodily organisation.' Hunter & Macalpine (1963) have credited Stewart with being the first philosopher to recognise the scientific potential of mesmerism, especially as he did so at a time when it was being derided as quackery by the medical establishment.

Thomas Brown succeeded Stewart in the Chair of Moral Philosophy. A precocious youth, he had at the age of 18 written an able critique of Erasmus Darwin's *Zoonomia* (Welsh, 1828). As well as his philosophical pursuits, Brown was a qualified doctor and he also published poetry of a decidedly sentimental nature. He had less to say about abnormal states of mind than Stewart, although he did discuss the impact on the mind of such disturbances as delirium or intoxication. In his *Lectures on the Philosophy of the Human Mind*, Brown (1820) drew together ideas from French, English, and Scottish philosophy to outline his theory of 'simple' and 'relative suggestion', by which he sought to explain the mechanisms of memory and the creative aspects of the mind.

The last of the three Edinburgh thinkers who made a contribution to psychology was Sir William Hamilton, Professor of Logic and Metaphysics from 1836 to 1856. He was an extremely widely read man who had studied medicine, law, literature, and language; indeed, Thomas De Quincey, who knew Hamilton, described him as 'a monster of erudition' (Veitch, 1864; 1883). He had travelled through Germany to acquaint himself with transcendentalist philosophy, and was especially influenced by the writings of Kant, whose faculty psychology he adopted. Hamilton's philosophy reflected a fusion of German and Scottish

thought, and he was regarded as the most knowledgeable and important British philosopher of his time (Veitch, 1882; Davie, 1961).

Hamilton's (1859) main interest for psychiatry is in his discussion of the unconscious actions of the mind. He was clearly fascinated by the subject: he arranged to be woken from deep sleep so that he could record his immediate recollection of dreams, and conducted several mesmeric experiments on his friends in his home. Hamilton contended that 'the mind may, and does, contain far more latent furniture than consciousness informs us it possesses' and that 'the sphere of our conscious modifications is only a small circle in the centre of a far wider sphere of action and passion, of which we are only conscious through its effects'. Hamilton discussed aspects of the unconscious operations of the mind under the heading of mental latency. He held that 'the infinitely greater part of our spiritual treasures, lies always beyond the sphere of consciousness, hid in the obscure recesses of the mind'. He also stated that the mind contained knowledge of which it was unaware in its conscious state, but which revealed itself during altered states such as 'madness, febrile delirium, somnambulism, catalepsy &c.' In support of his thesis, he quoted Benjamin Rush's account of asylum patients who displayed creative abilities only after becoming ill. Hamilton maintained that the unconscious activity of the mind could influence one's thinking: for example, he pointed out that there often seemed to be no obvious connection between two succeeding thoughts and that it was only by deeper reflection that one discovered that the thoughts were, in fact, related by reasons of which one had not been conscious but which were, nevertheless, known to the unconscious areas of the mind. Writing before Freud, Hamilton's discussions of the unconscious were innovative and exercised a profound influence on Thomas Laycock (1876), Professor of Medicine at Edinburgh in the mid-nineteenth century and author of the monumental treatise, *Mind & Brain* (1860).

The Edinburgh philosophers' interest in abnormal psychology found echoes in the literature of the period (MacQueen, 1982; 1989). Thomas De Quincey, the author of *Confessions of an English Opium Eater*, who later migrated to Edinburgh and could often be seen of an evening scurrying back to the debtors' sanctuary in Holyrood Palace, argued in his essays that childhood experience could be transformed by dreams into symbols which shaped the dreamer's personality (De Quincey, 1908; Lindop, 1985). James Hogg, who knew both De Quincey and Andrew Duncan (Hughes, 1990), wrote several pieces relating to insanity such as the *Strange Letter of a Lunatic* and *The Three Perils of Woman*, in which the heroine is confined in a private asylum in Edinburgh (Beveridge, 1991b). He is best known for *The Confessions of a Justified Sinner*, a classic novel of madness and religious fanaticism, which relates the story of a young man who sees visions, hears voices, experiences himself as two people, believes he has a double, and feels that he is under the control of another person (Beveridge, 1991c). As Gellner (1993) has suggested, Hogg's dark vision of destructive emotions could be read as a subtle refutation of Hume's benign account of the passions.

The Edinburgh professors' work did not go unchallenged, however. By the beginning of the nineteenth century, several voices were expressing their disenchantment with the Edinburgh philosophers' project to create a science of the mind. In 1804, Francis Jeffrey, the editor of the hugely influential *Edinburgh Review*, wrote an article which mocked at the ambitions of the philosophers. 'We cannot decompose our perceptions in a crucible, nor divide our sensations with

a prism. . . .’ The techniques of natural science, Jeffrey maintained, were inappropriate for the study of human beings. Another Edinburgh citizen also criticised the prevailing philosophy of mind, but from a different perspective. George Combe, a local lawyer, quite simply found the writings of the philosophers incomprehensible. His biographer tells us:

The philosophy of the human mind became at an early age the most interesting study to Combe. Whilst still a youth he read the works of Locke, Francis Hutcheson, Adam Smith, David Hume, Dr Reid, and Dugald Stewart. But he failed at first to understand them; and was baffled in his efforts to apply their principles to the explanation of the phenomena of active life . . . (He) then abandoned the philosophy of mind in absolute despair, as a mystery too profound to be penetrated by human intelligence. (Gibbon, 1878)

But salvation was at hand for Combe, who had been “reared in the gloom of Calvinist Scotland” and had suffered a series of religious crises concerning God’s government of the world (Gibbon, 1878). The doctrine of phrenology provided the answer to his quest, and, as he later wrote, ‘a flood of light . . . broke on my mind’ (Gibbon, 1878). Phrenology was the key that unlocked all mysteries about man and his environment. George Combe and his brother, Andrew were to become the foremost champions and publicists of phrenology in Britain, and Edinburgh thus plays an important role in the fortunes of phrenology.

Phrenology

While phrenology has often been derided as mere quackery, it is now recognised by historians to have played an important part in the development of psychiatric thought in the first half of the nineteenth century (Young, 1970; Bynum, 1974; De Guistino, 1975; Cooter, 1981, 1984). The scientific study of phrenology begins with the anatomical researches on the brain by a Viennese doctor, Franz Joseph Gall at the turn of the century. Gall’s research was guided by his belief that the different parts of the brain possessed specific functional properties. Together with his assistant, Johann Caspar Spurzheim he outlined the details of phrenology, which rested on the following principles: firstly, the brain was the organ of the mind; secondly, the brain was made up of a number of separate organs, each related to a distinct mental faculty; thirdly, the size of each organ was a measure of the power of its associated faculty; and fourthly, the correspondence between the contour of the skull and the cortex of the brain was such that the size of the organs and their potential role in an individual’s psychological make-up could be determined by inspection.

The Combe brothers’ role in the introduction of phrenology to Britain is crucial. George Combe was so impressed with phrenology that he persuaded his younger brother, Andrew to train as a doctor to better implement the new theory. Andrew subsequently studied in Paris with Spurzheim and also with Esquirol. Like his brother, he found the work of the Edinburgh moral philosophers frustratingly nebulous and of no practical use. He became converted to phrenology, which he hailed as the ‘key to the mind’ (Combe, 1850). In 1820, the Combe brothers established the Phrenological Society,

which drew members from many different social classes, including doctors and lay people alike. In December 1823, the first issue of the *Phrenological Journal* was printed in Edinburgh. As Jenkinson (1993) has demonstrated, phrenology drew support from a wide range of Edinburgh's medical men and she refutes Shapin's (1975) view that it inhabited only the anti-establishment margins of the scientific community.

In 1831, Andrew Combe published *Observations on Mental Derangement*, which attempted to demonstrate the 'application of the principles of phrenology to the elucidation of the causes, symptoms, nature and treatment of insanity'. Combe's book did more than any other publication to spread phrenological ideas to asylum doctors. He maintained that the brain could be disordered by mental as well as by physical causes, and thus was amenable to psychological intervention. As Bynum (1974) has shown, phrenology allowed for both a physicalist theory of insanity and a psychological method of treatment.

George Combe was responsible for popularising the wider implications of phrenology. His *Essay on the Constitution of Man*, published in 1829, was one of the most respected and widely read books of the mid-nineteenth century; and just as his brother had brought phrenology to a medical audience, so he brought the subject to the general public. The *Constitution of Man* offered the answer to all philosophical and social problems. It gave an essentially naturalistic perspective on man: the knowledge of the organisation of the brain which phrenology had unveiled led to an understanding of the scientific 'laws' governing human nature. Combe outlined the 'laws of nature', which man disobeyed at his peril: temperance, cleanliness, regular habits, and self-discipline. Combe (1828) declared that 'there is a direct Divine government of the world, and that its laws are plainly written in Nature for the benefit of man.' Cooter (1984) has noted that we see the values of Combe's Calvinist upbringing writ large in the 'scientific' prescriptions of the *Constitution of Man*. Combe's book promised social progress and self-improvement, and his message was enthusiastically received by contemporaries. He was sought after to deliver lectures throughout Britain and America, asked to pronounce on social issues, and summoned to Buckingham Palace by Prince Albert to advise on the phrenological development of the Royal offspring.

However, not everybody greeted phrenology as the panacea for the ills of humanity; indeed, it was received with great hostility in some quarters. The argument concerning the validity of phrenology as a scientific theory found its greatest dramatic expression in the debate which was fought in Edinburgh throughout the late 1820s and 1830s (Cantor, 1975; Shapin, 1975). Ranged against phrenology were Francis Jeffrey, the Common Sense philosophers, Sir William Hamilton, Thomas Brown, and certain medical men. The Combes and their followers were fighting to establish phrenology as the true science of mind in place of what they perceived as the vague, metaphysical vapourings of the Common Sense school. They contended that philosophers had studied mind without reference to the underlying brain, while anatomists had studied the brain without reference to the mind. Phrenology bridged this divide and provided an explanation of mind-brain interaction. In reply, moral philosophers held that the mind was an immaterial entity and rejected the phrenologists' model of mind-brain interaction. Likewise, anatomists of an antiphrenological persuasion rejected the phrenological view of the brain as a set of localised functions;

instead, they saw the brain as a unified and integrated system. Brown also accused the phrenologists of appropriating the moral philosophers' description of the 'faculties' and reifying them as actual structures in the brain, when they were merely concepts.

The phrenology debate generated great interest in Edinburgh in the early part of the nineteenth century. When Andrew Combe delivered a lecture to the Royal Medical Society of 1823, in response to the question, 'Does Phrenology afford a satisfactory explanation of the Moral and Intellectual Faculties of Man?', the subsequent debate continued over two evenings and finally ended at four o'clock in the morning, with both sides claiming victory. Indeed, the two sides never resolved their differences, and Cantor (1975) has suggested that it was impossible for phrenologists and anti-phrenologists to find a middle-ground, because they started from mutually incompatible premises concerning the nature of mind and brain, and of scientific methodology. Interest in phrenology eventually waned, but it is important to recognise its legacy. In Edinburgh, it undermined the Cartesian dualism of philosophy, which treated mind and brain as separate entities; phrenology emphasised that the two interacted closely. More generally, phrenology removed psychology from philosophy and placed it firmly in biology. As G.H.Lewes wrote of phrenology's creator, Joseph Gall, 'he rescued the problem of mental functions from Metaphysics, and made it one of Biology' (Young, 1970). The phrenological project to delineate specific functional areas in the brain, although simplistic, led to the work on cerebral localisation later in the century.

Phrenology also provided a welcome guide to the emerging asylum doctors, who saw it as a useful framework within which to understand their patients. It provided a means of classifying the mental attributes of inmates by inspection of their heads, and it also suggested a means of treatment. The thesis that psychological factors influenced the functioning of the cerebral organs made legitimate the use of psychological techniques to treat insanity which alienists considered was caused by brain disease. Several Edinburgh graduates became phrenologists, notably John Conolly, who was exposed to the theory during his student days, W.A.F. Browne, whose friendship with the Combes had first stimulated his interest in mental disease, and Richard Poole, who was an early editor of the *Phrenology Journal*.

Phrenology had a major influence on lay people, too. The Edinburgh publisher, Robert Chambers (1844) drew on the tenets of phrenology, especially as espoused by George Combe, to write *The Vestiges of the Natural History of Creation*, a book which occupies a significant place in the history of nineteenth-century evolutionary theory. Young (1985) has judged that although Chambers' science may have been rudimentary, 'his generalizations were of fundamental importance'. The book anticipated the evolutionary theories of Charles Darwin, who thought it 'strange, unphilosophical but capitally written' (De Guistino, 1975). Chambers used the phrenological concept of natural law to argue that the laws which applied to the history of the earth should also apply to the history of life. The phrenological principle of the uniformity of nature implied that the laws which obtained in the rest of the natural world also governed man and his mind. Chambers' book created a major controversy in religious circles, as it was perceived to undermine the role of God in creation, and, for many years the author remained anonymous while the row blazed. Indeed, it has been

demonstrated that Chambers' book created a greater impact than Darwin's *On the Origin of Species* of 1859 (Young, 1985). As Darwin's most recent biographers (Desmond & Moore, 1991) have shown, the youthful Charles first witnessed the fiery battles between religion and science in Edinburgh where, as a medical student, he had attended the debates at the Plinian Society. Interestingly, he had been proposed for membership by a fellow student, W.A.F. Browne, a radical and a religion-baiter, whose address on mind and matter had provoked acrimonious dispute at the Society (Walmsley, 1993). It has been suggested that Darwin's experience of these stormy Edinburgh debates contributed to his later reluctance to make his own views public, lest he court similar controversy (Desmond & Moore, 1991).

Conclusion

This chapter has covered a wide time-span. Inevitably, there is the risk of the over-simplification of complex issues, and there is also the problem of judging which episodes to emphasise: those which have received scholarly attention may be overstated at the cost of more neglected areas. Further, in concentrating on a single city, there are the twin dangers of parochialism and the exaggeration of its achievements. This is particularly acute in the context of the recent explosion of interest in Scottish history which is witnessing a major reassessment of many aspects of the country's past (Lynch, 1991, 1993; Donnachie & Whatley, 1992). Likewise, the history of psychiatry is also undergoing scholarly reappraisal. In *Rewriting the History of Madness*, Still and Velody (1992) have criticized both the older, triumphalist versions of psychiatric history which chart a rising curve of development, and the newer historiographies of antipsychiatry which they characterise as 'Whiggishness in reverse'.

Bearing such considerations in mind, how should Edinburgh's contribution to the origins of psychiatry be assessed? It is surely not unreasonable to conclude that Edinburgh's contribution has been a major one. Indeed, if one wished to write an account of the evolution of psychiatric thinking in Britain during this period, but only had access to what happened in Edinburgh, one would still be able to construct a fairly comprehensive account of events: which is to say that Edinburgh participated in and contributed to most of the significant episodes in the history of British psychiatry during this time. Thus, the delineation of nervous diseases, the attempts to construct a philosophy of mind, the rise and fall of phrenology, the enquiries into mesmerism and the unconscious, and the first lectures in mental disease were all enacted on the Edinburgh stage. In addition, many of the key players in the emerging specialty of psychiatry were Edinburgh graduates.

Of course, the events in Edinburgh did not take place in isolation. As Lynch (1991) has shown, Scotland has long been a cosmopolitan nation which has participated in many of the leading intellectual and cultural movements in Europe, and during the period discussed here, there is much evidence of the exchange of ideas between Edinburgh and other places. The Edinburgh medical school borrowed from the Dutch model, and in turn influenced the rest of Europe and America. Cullen's views on insanity inspired Pinel, and the Paris school subsequently became the mecca to which aspiring Scottish alienists like Morison

and Browne made their pilgrimage. Edinburgh's philosophers drew on the work of English, French, and German writers, and they themselves made a significant impact on European and American thought. Phrenology was imported from Austria and enthusiastically adopted by two Edinburgh brothers, who helped to popularise the theory for a wider British and American audience. The merits of the York Retreat were most loudly proclaimed in the pages of the *Edinburgh Review*, and its ideals informed the early philosophy of the Edinburgh Asylum.

Many of the later developments in psychiatry have their origins in this era. For example, Porter (1988a; 1991) has suggested that Cheyne's *English Malady* and Trotter's *View of the Nervous Temperament*, with their depiction of the diseases of civilisation, could be seen as early versions of psychiatric epidemiology. More generally, the whole thrust of the Scottish Enlightenment was a profound interest in man as a social being, and this interest can also be discerned in Combe's phrenological prescriptions for society, in Laycock's (1857) work on public health, in Clouston's (1906) programme of mental hygiene, and, later, in Henderson's (1964) pronouncements on society and psychiatry. Interest in the social aspects of mental disease can also be traced in Morison's attempts to treat patients outwith the asylum, and his approach could be regarded as a forerunner of community care.

The eighteenth-century preoccupation with 'nerves' has some parallels with today's interest in psychotherapy. In both cases, we see mental distress enjoying a certain fashionability amongst the more affluent circles in society, and in both we see a vogue for consulting with self-advertising therapists. Likewise, the focus of attention in both has been on the individual experience of the sufferer. In Edinburgh's most famous 'hypochondriac', James Boswell, we see personified many of the characteristics of the age of sensibility; indeed, as John Wain (1975) has observed, if Samuel Johnson is representative of the older, Augustan ideals of order and rationality, then his most famous biographer reflects the new age's fascination with the self and *difference*. Such preoccupations have a modern quality to them and help to explain Boswell's appeal to our own times.

The investigations of Stewart, Brown, and Hamilton into the properties of the mind could be seen as anticipating psychoanalytical theory, although their work has often been overlooked in standard accounts of the subject (Ellenberger, 1970). Long before Freud, these Scottish philosophers were exploring the uncharted territory of the unconscious in their study of dreams, hypnotism, and memory. In parallel, physicians such as Ferriar, Abercrombie, and Crichton, and writers such as De Quincey and Hogg surveyed the terrain of abnormal psychology, and brought back accounts of illusions, hallucinations, and doppelgangers.

Phrenology has been rescued from the rubbish-bin of history marked 'quackery', and is now judged to have paved the way for the discovery of cerebral localisation in the second half of the nineteenth century. Phrenology's main legacy was to insist that the brain was the organ of the mind, and that it could best be understood in terms of localised functions. Its influence has also been acknowledged in the twentieth century: for example, Crichton-Browne declared in 1924, 'We are all phrenologists today,' and this sentiment has been echoed by Hunter & Macalpine in 1963, and again by Robert Young in 1985. Today's advances in neuro-imaging continue the phrenological project to construct a map of brain functions.

Other fields of enquiry into mind and brain during this period have also been influential. Thus, Robert Whytt's description of the reflex function of the nervous system contributed to nineteenth-century advances in neurophysiology, and his influence can be traced in the work of Thomas Laycock. Morison's physiognomy plates were the direct predecessor of attempts later in the century to capture the faces of madness by photography, an enterprise which involved both Crichton-Browne and Charles Darwin (Browne, 1985; Oppenheim, 1991). Darwin's evolutionary theory, which owed a debt to the knowledge he acquired during his student days in the Scottish capital and which had been anticipated to some extent by the Edinburgh publisher, Robert Chambers, exercised a profound influence on late nineteenth-century British and American psychiatry. In the late twentieth century, Darwin's ideas are once again being drawn upon in an attempt to construct an evolutionary model of the psychoses (Crow, 1994).

Many of the tensions between opposing representations of mind and body are evident during this period, symbolised most strikingly in the Edinburgh phrenology debates. These tensions have a long history (Rousseau & Porter, 1990), and they are still with us today, as Charlton (1990) has shown in his critique of the limitations of 'biological' psychiatry. While the heirs of phrenology and a physicalist perspective on mental disease are currently in the ascendancy, other perspectives should not be ignored. Indeed, as Flynn (1992) has observed: 'At this moment, when the resources of neuroscience and artificial intelligence are being applied in the study of cognitive activity, it may be worthwhile to review the record of the Scottish philosophy or science of mind in the eighteenth and early-nineteenth centuries . . . most of them believed what some modern scientists have acknowledged only with reluctance – that cognitive activity cannot be explained in purely neurobiological terms.'

Flynn's observation takes us back to Gregory's plea, quoted at the beginning of the chapter, that both physical and mental factors should be considered in the study of human beings. The many accounts of madness examined here have proposed differing models of mind-brain interaction, and it is not the intention to conclude by offering a resolution of the conflicting opinions aired; indeed, as Brown (1993) and Goldstein (1993) have shown, disagreement about the relationship between mind and body has been a recurring theme throughout the history of psychiatry. Rather, by outlining the variety of views espoused in Edinburgh between the 1730's and 1850's, an attempt has been made to convey something of the diverse nature of the origins of psychiatric thought.

Acknowledgments

I am grateful to Michael Barfoot for his advice with this chapter, to Joy Pitman for her help with the records of the Royal College of Physicians of Edinburgh, and to Nick Hervey for allowing me to read his chapter on Alexander Morison prior to its publication.

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18 Mental Mischief: aspects of nineteenth-century psychiatric practice in parts of Wales

T.G. DAVIES

'Sins against the physical and moral laws work mental mischief. This, our town of Swansea, is constantly sending contingents to swell the ranks of the unfortunate insane.' (*The Cambrian*, 1886).

It was once said that psychiatry has a long past, but only a short history: in Wales, that history has been particularly short. Halliday (1827, p. 72) put forward the view that among the Welsh there were 'very few lunatics and the same remark holds good with regard to the Celtic tribes in other portions of the Empire'. Dr Samuel Hitch, the Medical Superintendent of the Gloucester County Asylum, once described as 'that able, bustling and intelligent man' (Walk & Walker, 1961, p. 607), was less patronising and better informed. In a letter to the *Times* in 1842, he showed that on a recent visit to north Wales, he had found evidence of:

a frightful exhibition of the demented amongst our Welsh neighbours
... [The whole situation represents] a blot upon Welsh humanity.

Particularly disturbing in the mid-nineteenth century was the high proportion of 'single lunatics': in the absence of any other form of care, they were left in the hands of their families or anyone else who might wish to take charge of them on being paid a small weekly sum. The report of the Metropolitan Commissioners in Lunacy (1844) following a visit to Wales, described a similar situation. Their task was to assess the standards of care available for the psychiatrically disabled in the Principality, and they could hardly have expected to find that more than three-quarters of those known to be so afflicted were being inadequately cared for (Davies, 1980). In south Wales, it was considered by some families that having mentally-handicapped children was an actual advantage, in view of the weekly payments for them. The single lunatic system of care continued to be used in Wales to a greater extent than was the case in the English counties: in 1847 (Lunacy Commissioners, 1847-8, p. 764), about 77% of Welsh patients lived under such conditions, and even by 1860 (Lunacy Commissioners, 1860, p. 321) of the 1,754 patients known in Wales, as many as 988 were in single care, while there were only 44 out of a total of 3,686 in the county of Middlesex. However, few in authority regarded this matter as being of great importance. To a large extent, the notion that the Welsh counties were merely distant and

impoverished versions of rural England at its most unacceptable was implicit in their thinking. Among the striking exceptions were Lord Ashley (later the seventh Earl of Shaftesbury) and Hitch himself, who were both aware of the linguistic differences that existed between Wales and England and of their significance in the management of the mentally disturbed. They also knew that to ignore such matters could only have a deleterious effect on an already underprivileged section of the community. As Hitch put it so graphically, 'I have known an instance of an individual becoming master of himself on quitting the control of those whose language he did not understand'.

The Poor-Law System

By the 1830s, efforts were being made to furnish alternative forms of care, the most commonly used of which was itself frequently inadequate. Unable due to population growth to cope with the increasing demands that were being made on them during the first half of the nineteenth century, the Welsh poor-law authorities were left to provide facilities for the mentally ill, though they had neither the resources, the ability, nor only too often, the desire to do so, and rarely adopted a generous attitude towards them. (Unusually, towards the end of the eighteenth century, paupers from Denbighshire were sent to un-named 'health resorts and to the seaside' to recuperate after illness (Hughes, 1945, p.50), but it is surely inconceivable that the psychiatrically disabled should have received such treatment.) Disputes concerning the liability of individual parishes to care for the mentally ill occurred not infrequently in western Glamorgan. (Davies, 1994, p. 80) Advertisements would sometimes be placed in newspapers asking for information about their parish of origin (The Cambrian, 1870), and at times, the matter would only be settled, at considerable cost, by a court action (The Cambrian, 1848), which might even reach the Court of Queen's Bench (Law Journal Reports, 1846). Earlier, a Swansea barrister, (Socckett, 1821, p. 24) had complained of the 'extreme facility with which the profligate and idle obtain relief', and such an attitude could hardly have made the treatment of psychiatric patients easier.

On the other hand, William Day, one of the Assistant Poor Law Commissioners working in Wales, (Lewis, 1964, p.180), had little patience with the Guardians with whom he was expected to co-operate. In one of his more despairing moods, he wrote, in 1840:

you cannot know the miseries of thirty or forty Welsh guardians who *won't* build a Workhouse and consequently meet in the parlour of a pot house twelve feet by fourteen and keep all the windows shut and spit tobacco on your shoes – to say nothing of knowing not a word of what they are talking in an unknown tongue.

In fact, he seems to have understood the nature of the problems with which they were faced. The Commissioners' records for the western part of Glamorgan, with its two Poor Law Unions based in the towns of Swansea and Neath, frequently give the impression of a system overwhelmed with a multiplicity of other difficulties. These were often of a life-threatening kind, so that a neglect of psychiatric

matters, reprehensible though it seems to the present-day observer, was almost inevitable.

The passing of the Poor Law Amendment Act of 1834 may have represented a more important step forward in the management of the mentally disturbed in Wales than was the case in England. It has been suggested (Hughes, 1945, p. 185) that the Lunacy Commissioners' right to visit workhouses where psychiatric patients were kept accounts for the fact that the Poor Law Commissioners failed to produce a firm policy for dealing with the mentally ill. However, so far as can be made out, there had never been such a policy in existence. This was not so in the case of the Lunacy Commissioners: within 11 months or so of their assuming those additional duties (Lunacy Commissioners, 1847, pp. 339-40), they had visited more than 300 poor-houses throughout England and Wales. In 1873, it was decided that a conference, to which all the south Wales Poor Law Boards of Guardians sent delegates, should be held to discuss their common difficulties. There, the Swansea Stipendiary Magistrate, J. C. Fowler, reviewed the range of work undertaken at poor-houses (The Cambrian, 1874). These included a hospital function and a use as a place of safety, where poor imbeciles could be kept; vagrants and physically well paupers were to be made to work, and illegitimate children and their mothers could find refuge. Therefore, considering the wide range of responsibilities, there was little hope that the psychotic and mentally handicapped would find solace there. The suggestion (Webb, 1910, pp. 49, 62) that there should be separate psychiatric wards was hardly ever taken up in Wales, even though the situation at the Neath Workhouse, which was 'full of old and imbecile paupers' (The Cambrian, 1874), was fairly typical of the whole Welsh situation. The south Wales Poor Law authorities were generally reluctant to transfer their impoverished patients to English asylums, on the grounds of cost. Consequently, following the increase in population that occurred with the coming of the industrial era, it was inevitable that the workhouses should have to continue accepting more patients than had been planned for.

There were many who believed that new psychiatric facilities were too expensive a commodity to be paid for from the public purse; such an argument was put forward at the Neath Union in 1855, when discussions were held concerning the need for a county asylum (The Cambrian, 1855). This view was reinforced, curiously, by the translation into Welsh of Bircham's booklet of instructions for Guardians (1895, p.20), in which they were again warned of the onerous nature of their duties. They were cautioned against excessive spending of public money, and were reminded that they were not involved in the administration of charitable trusts. It was emphasised that the funds entrusted to them were raised by the payment of compulsory rates, and that many ratepayers were ill able to afford to pay sums that were to be spent on the 'unworthy and ignorant' poor. It was also stressed that padded rooms must be provided in workhouses. This, in turn, helped to encourage a reduction in the admission rate to asylums, even though the Lunacy Commissioners had maintained that as a result of this policy, many were denied treatment as well as often 'the comforts and indulgences their malady or their helplessness so urgently needs' (Lunacy Commissioners, 1868-9, pp. 86-7), which were only available in the asylum setting. Nevertheless, where it seemed obvious that little was to be gained from asylum treatment, because of the advanced nature of the disease, they accepted that such patients should be sent to the poor-house (Lunacy Commissioners, 1857, p. 373). There did

occur, though, curious anomalies at that time. Throughout the workhouses of west Wales (Lunacy Commissioners, 1861, p. 135), in 1860, the visiting Lunacy Commissioners 'rarely found any cases requiring treatment in an asylum', though they offered no explanation for this finding in their report. On one occasion (Hughes, 1945, p. 267), in 1885, in north Wales, Boards of Guardians 'strongly disapproved' (seemingly to no avail) of having to care for the mentally ill, as there were no suitable facilities or sufficiently skilled staff available.

Though it was believed that pauperism could only rarely be attributed to psychiatric illness (*The Cambrian*, 1868), about a tenth of the population of England and Wales was receiving poor law relief, so that a less expensive means of dealing with the problem had to be sought (Lunacy Commissioners, 1860, p. 321). Consequently, (Lunacy Commissioners, 1863, p. 466) as many as 26 % of the known patients were kept in workhouses, and this tendency continued at least until the end of the 1860s. When the Monmouthshire County Asylum was opened in 1851, the comparative costs of maintenance followed the general trend for the British Isles (Lunacy Commissioners, 1844), with the weekly expense per patient (12 shillings a week) being three or four times that of the cost of maintenance in a workhouse. It was difficult to ignore public opinion on such matters; unspecified sources had made it known to the Poor Law Commissioners that it was widely believed in south Wales that the poor law, as well as the asylum system, was too expensive. It was also accepted by many that those employed there, particularly the part-time medical officers, were paid at an excessively high rate (Poor Law Commissioners, 1844, p. 35). (No such protest was voiced in 1872 (*The Cambrian*) when it was made known that the cost of maintenance of prisoners in south Wales gaols varied from eight shillings and nine pence to thirteen shillings and twopence a week.)

Though unwilling to spend larger sums in developing their psychiatric role, the Guardians' attitude towards the provision of alcohol for the residents of the workhouses was paradoxical. In 1838 (Lunacy Commissioners,) the medical officers at Swansea were warned that they were prescribing excessive quantities of wine for sick patients. By the early 1870s, that was believed to be the case throughout south Wales – a view that was confirmed by the evidence gathered for the Select Committee concerned with the use of alcohol (House of Lords Select Committee, 1878). The whole question of the overprescribing of alcohol was eventually taken up by the Swansea weekly newspaper, *The Cambrian*. It was discovered that at the Neath Workhouse (*The Cambrian*, 1875), for reasons that remain unclear, the Guardians insisted on prescribing alcohol in the case of alcoholic patients (the 'habitual drunkards' of that age), even when the medical officer had described their action as being tantamount to euthanasia. After castigating the Neath Guardians for the way in which the workhouse was being administered, the editor of *The Cambrian* went on:

one class of persons, however, will be perfectly satisfied with the workhouse arrangements. We refer to habitual drunkards, whose habits have made speedy death a certainty . . . Drunkards of Neath rejoice, drink enough to get Bright's Disease and make your case hopeless, then enter the Neath Workhouse, and die quietly on half a bottle of gin a day.

The medical staff frequently refused to alter their prescribing practices,

unless they were instructed to do so by the Guardians (Neath Poor Law Guardians, 1878). This uneasy relationship between the Guardians and the doctors employed by them was to continue for as long as the poor-law system had to assume responsibility in the psychiatric sphere. The solution to the problem only came with greater recognition that this group of patients required more specialised help than the poor law system was able to provide.

Asylum Care

As increasing numbers of serious crimes were referred to the assizes, the quarter sessions authorities had assumed more administrative responsibilities (Davies, 1990, p. 262). Their 'county business', which was taken over by the newly-formed county councils in the late 1880s, included the opening and management of county asylums. At first, Welsh justices of the peace, sitting in quarter sessions, were rarely prepared to spend large sums of money in this field. An insufficiently large and comparatively poor population accounted for the lack of need for private asylum accommodation during the first three decades of the nineteenth century. Therefore, the age of the lunatic asylum was comparatively late in coming to Wales, and even then, the service provided was limited in extent and varied in its quality. The privately-owned May Hill's House was opened at Swansea in 1815, though no licence was sought from the Quarter Sessions court until two years later, probably because there were too few patients for that to have been necessary at first (Davies, to be published). The medical attendant there, Dr Thomas Hobbes, had already worked as a physician for 35 years, and was able to claim that throughout his career (that is, from about the year 1780 onwards), he had 'paid particular attention to the subject of insanity'. Virtually nothing is known about the place although, when it was enlarged some years later, he wished:

to assure those who may be disposed to entrust him with the care of their relatives . . . that every attention will be paid to [them], particularly as regards air and exercise and that the disorder will be treated upon the mildest and most humane plan.

In 1819, the best of Glamorgan diarists and one of the most sedulous of that county's magistrates, Lewis Weston Dillwyn, had cause to visit there twice within a few days:

I rode to Swansea [with] Mr Jones of St Helen's, with whom I have joined for several years as visiting magistrate of the lunatic asylum. It was in consequence of a charge brought by Dr Mitchell against Dr Hobbes of his having treated a Miss O. who is confined there with . . . harshness, and my opinion is that the charge is groundless. (Dillwyn, 1819)

So far as is known, the house was closed after Hobbes's death in 1820, so that it was probably only open for five years or so.

The work of Charles Watkin Williams Wynn, the MP for Montgomeryshire, in introducing legislation which allowed quarter sessions courts to open their own

asylums for pauper and criminal patients, had little effect in Wales for many years. The first county asylum to be opened in the Principality came into being in one of the most remote and poorly populated areas. Geographically within the county of Pembrokeshire, Haverfordwest had been granted the status of a 'free town', since Tudor times (Green, 1863, 197), and was known as the 'town and county of the town of Haverforwest', with its own Lord Lieutenant, Commission of the Peace, and Quarter Sessions court. In 1822, (Inhabitants of Haverfordwest, 1822, 51) a petition was sent to parliament 'setting forth that it would be of public utility if the present gaol . . . were relinquished'. Shortly afterwards, an Act (3. Geo IV. cap. lxxiii) (Jones, 1966, p. 215) which sanctioned the use of that building as a county asylum for Haverforwest and Pembrokeshire received the Royal Assent in June of that year (Davies, 1992-1993).

With the passing of that Act, there opened what was probably the most discreditable episode in the history of psychiatry in Wales. Although the magistrates from Pembrokeshire and the Haverfordwest Justices and sheriff, had an unlimited right to visit the new asylum, they obviously failed to do so as regularly as Dillwyn had done at Swansea. Parliamentary returns show that several of those kept there before the building had changed its function were mentally ill, and had been there for lengthy periods, one having been 'committed near forty years'.

The whole history of the Haverfordwest asylum highlights the continuing difficulties which met the earlier attempts to bring about improved standards of care for the impoverished psychiatric population. Although the keeper and his wife, the matron, seemed 'well disposed' towards their patients, they were themselves virtually paupers, and as a result, he had taken other additional employment. (When the asylum staff was enlarged later, their wages were less than the average cost of maintenance of psychiatric patients throughout Wales.) Following the Lunacy Commissioners' persistent protests concerning the state of the place, the opinion of the Law Officers to the Crown was eventually sought as to the most suitable course of action. No legal proceedings ensued, as it was believed that this could not have been justified in a court of law. However, the magistrates were warned that unless a new set of rules of management was formulated, it might be necessary for a writ of *mandamus* to be issued against them, as a result of which they would be ordered by a higher court to implement the recommendations that had been made. There followed a slight, temporary improvement in conditions at the asylum. The visits made by a local magistrate, or sometimes the mayor, who were invariably escorted by a policeman, had little impact, and by 1848, there were difficulties of a different kind. The medical officer, Mr Millard, a local surgeon, had to appear at the town's magistrates' court, having been charged with failing to make any entries in the medical journal and ignoring their requests for information about the nature of his work. To the Commissioners' regret, even though he had been found guilty on two charges of neglect, the lowest possible penalty allowed was imposed, when he was fined ten pounds and was allowed to retain his position.

By the following decade, Shaftesbury and his colleagues considered that the asylum was overcrowded with 37 patients, even though it was said that there was available sufficient room for 40. They believed that:

as a place for the reception of the insane, the Haverfordwest asylum is deplorably and incurably defective. It retains unaltered its original

character and aspect of a gaol, and in point of space, cheerfulness and convenience, is inferior to many gaols. [There is] no sufficient means of separating the violent and raving from the quiet and convalescent inmates . . . In short, the asylum though possibly a place of safe custody is extremely ill adapted for the treatment and care of insanity.

Mr Millard's failure to adapt to the changing needs of the developing psychiatric services caused Shaftesbury and his colleagues more than a little concern: the fact that mechanical restraint continued to be used there on his instructions was thought to be a disgrace. The level of their despair at his unwillingness to alter his views can be seen in their recommendation, made in 1857, that most of the patients should be transferred to workhouses near their homes, where it was thought they would be more adequately cared for. It was also considered that the medical officer himself should no longer continue in his position. His successor's standards were no higher, and the magistrates were to be blamed to a large extent for that; it was surely one of the major tragedies of that age that it was they who were given the power by Parliament to license asylums. As a result, the Commissioners often assumed no more than an advisory role, and generally seemed not to have been inclined to criticise magistrates for what amounted to an obvious failure to carry out their duties; the temperate manner adopted by them in commenting on the management of this asylum was quite remarkable. Despite their suggestions, with the exception of some short-lived improvements, conditions at the asylum failed to improve, and there were few changes over the 40 or so years for which the place remained open. By 1866, however, 'the inmates had all been removed to [the joint counties' asylum at] Carmarthen . . . and the question now arose as to what was to become of the building' (*The Cambrian*, 1866).

As might have been anticipated from more recent experience, the private sector benefited from the State's failure to accept its responsibilities for providing the appropriate services. The third Welsh asylum, Vernon House, was again privately owned, and was at Briton Ferry, on the outskirts of the town of Neath, in Glamorgan. Robert Valentine Leach was a failed corn merchant, who came to the county in 1843, at a time of prosperity. Between the beginning of the century and the early 1840s, the county's population had virtually trebled, as the transition from a largely agricultural to an industrial economy took place. Almost 20 % of the population of Wales lived within its boundaries, and shortly it would become the only county in Wales with more than a half of its inhabitants living in towns (Davies and Mungay, 1980, p. 293). Most important, with the exception of the facilities at Haverfordwest to which, mercifully, patients from elsewhere were never sent, there was no other asylum in Wales at the time. Vernon House remained open for more than 50 years, and until the Glamorgan County Asylum started to accept patients in 1864, the facilities there were extensively used in providing for the poor mentally ill by several south Wales quarter sessions courts.

The fourth (and last private) institution to be opened in the Principality was again in Pembrokeshire. Amroth Castle had been described earlier as 'a castellated mansion, delightfully situated on the coast, where the air is as mild and salubrious as in Devonshire'. The owner, Dr John Howard Norton, had studied medicine at the Universities of Paris and Edinburgh, and had been a member of the University of Palermo. In 1851, his application for a licence to

take 56 patients, of whom at least 48 were to be paupers, was successful. Less so was his career as a psychiatrist in rural Wales. He was the first Welsh doctor known to have become a member of the Association of Medical Officers of Asylums and Hospitals for the Insane. Despite the fairly widely-held belief that only the most enterprising of asylum doctors sought membership of the Association, Norton proved to be the exception to that rule. The discrepancies between the low standards of practice at Amroth Castle and his reports on the condition of the house are striking. The use made there of extreme forms of physical restraint and the existence of the most primitive living conditions as late as the early 1850s contrasted sharply with his replies to a Lunacy Commissioners' questionnaire, when he wrote:

the management of the insane . . . should be the same as nearly as possible for the sane . . . with careful and kind conduct on the part of the attendants, not one case in 100 requires restraint in the daytime . . . patients [here] are treated . . . in the same manner as those with whom they are associated in the performance of the duties of the farm, garden and household.

Although the magistrates saw no reason to close the asylum, this was brought about in 1856, following a report to the Lord Chancellor by Shaftesbury, in which he wrote that the justices' views:

are not always in agreement with the views expressed by Visiting Commissioners . . . it is only in cases of great abuse that we can feel justified in adopting the extreme course of applying to your Lordship for a revocation of the license.

As early as 1807, a parliamentary Select Committee (House of Commons Select Committee, 1807) had recommended that a concerted attempt should be made to build public asylums. Two of them, both on the English side of the border at Hereford and Chester, would serve the whole of Wales as well as both those counties. That view seems to have been superseded by the passing of Wynn's County Asylums Act which, admirable as it was in principle, placed no compulsion on individual counties to provide for their mentally disabled. Nor were the Welsh Quarter Sessions courts generally more sympathetic in terms of providing asylum accommodation themselves. In Glamorgan (Davies, 1993), the most populous of the Welsh counties, a lunatic asylum committee had been formed by 1830, but its existence seems to have done little more than acknowledge that there was a problem of that nature. During the same decade, the families of two of the county's ironmasters donated sums of money for the building of an asylum. (The first sum, appropriately enough, had come from a fund formed as part of the 'general rejoicing' to celebrate the jubilee of George III and had originally been intended to help small debtors in jail.) As there was a possibility that parliamentary sanction might be obtained to build a new county prison, that building might have been 'render[ed] useless', and, as had been the case at Haverfordwest, it was thought to have been suitable for this purpose. However, as nothing had been achieved by 1837, it was decided to place the care of the 100 or so impoverished mentally disabled of the county's residents in the care of 'any medical practitioners of eminence and respectability' who might

wish to undertake that task. This course of action, though, was not acceptable to everyone.

On the one hand: 'a county so important as Glamorgan should have its own lunatic asylum, under the care of an intelligent resident medical officer, capable of putting into operation the most successful moral and medical treatment'. The counterargument was that there was little justification for increasing the £700 or so a year which the county was already spending on mental health problems, as the running costs of such an institution would be more than seven times that sum. It would be far more reasonable, it was said, for space to be made available for patients throughout the county's five workhouses. These protests, and the fact that no eminent and respectable doctors showed any interest in the venture, between them disposed of both suggestions, but the matter was not allowed to rest there. The view originated in Glamorgan that negotiations should be started with a view to creating a large asylum for the whole of south Wales; that venture, though, failed with the disbanding of the asylum committee, because of the costs incurred in the rebuilding of the prison.

Possibly because of the opposition voiced when the matter was raised again in 1843, the chairman of the Quarter Sessions court, John Nicholl, arranged for a survey of the prevalence of psychiatric disorder within the county to be conducted. Of the 45 pauper lunatics and 58 idiots identified, less than 14% were having asylum care, while nearly twice that number were thought to be 'dangerous'. This information seems to have stirred the court into reforming the asylum committee, as:

it is notorious that the chance of recovery of persons inflicted with insanity depends, in a great degree, on their early removal to asylums . . . in Wales, where a peculiar language prevails, the necessity of local lunatic asylums is especially urgent . . . it is not fit that in this wealthy and populous county this state of things should be allowed to continue . . .

There was a body of opinion within the reconstituted asylum committee which would have favoured handing over the care of the pauper patients to the owner of the recently-opened Vernon House. The efforts made by Leach to press this course of action were not encouraged by Nicholl. In spite of that, he did recognise that by accepting Leach's offer, the court might avoid having to find large amounts of capital in the short term, while more time would then be made available for the planning of a future county asylum. Leach was also asked if he would consider the possibility that Vernon House itself might be used for that purpose, if he were to be made Governor. This he refused, presumably because such a course of action would have been financially disadvantageous to him.

Although Nicholl had made it known to the court that there had recently occurred 'a great diminution of expense . . . in the building of asylums', Leach's arrival had to some extent lessened the need for immediate action. From the approaches made by him to representatives of at least two other Welsh counties, it seems likely that he intended to try to establish a monopoly on the care of the impoverished mentally ill, possibly throughout the whole of south Wales. His own presumptuous attitude was, to some extent, responsible for the failure

of that plan; moreover, it did seem that the building of a large county asylum for the whole of south Wales was not without its attractions. Several objections to this were raised from within the county itself, and there were few among the magistrates who were sufficiently dedicated to the idea to enable them to overcome the apathy of the majority. The protests centred around the effect of the repeal of the Corn Laws on the county's economic situation, and moves that were being made to rebuild the county's roads, which together would have a disastrous effect from the point of view of many ratepayers. Nicholl's belief that the nature of the county warranted a union with Monmouthshire was ignored, and efforts were made to establish a link with the agricultural counties of south-west Wales. It had become apparent by then, at least to some of the Justices, that they ought to seek the advice of 'some professional gentleman of established reputation in the cure and treatment of the insane'. They chose well in asking Dr Samuel Hitch, already familiar with the Welsh situation to some extent, from his earlier visit to north Wales. In his two splendid reports of January 1846, he came to the alarming conclusion that of the 170 pauper patients (about a half being 'idiots') who lived in Glamorgan, 'there does not appear to be a curable case. This is a melancholy picture that I have not elsewhere seen'. He raised objections to the use of Vernon House as a county asylum on anything other than a temporary basis, and even after bringing about several structural alterations, only 100 or so patients should be accepted there. He was also adamant that the court should employ its own staff, to the exclusion of Leach. The overwhelming conclusion drawn, though, was that it was necessary to think in terms of having asylum accommodation rather than 'a hospital for the cure of the disease'. In the event, Leach refused to sell the lease of the house, and little was achieved, except that he continued to benefit from the quarter sessions court's failure to find another solution to the problem, and continued to accept the county's impoverished patients for many years more.

Nicholl, who was also the MP for Cardiff, and possibly impatient with the slow pace of the discussions, put a parliamentary question on the matter to the Home Secretary in 1847. He asked if it was intended to absolve those counties without asylums from the need to build them, and he had almost certainly anticipated Sir George Grey's reply. He was informed that the aim was to issue writs of *mandamus* to those quarter sessions courts which had made no provision, in order to force them to do so. Following this, the pace at which the talks proceeded between the south Wales counties was accelerated, and the Monmouthshire authorities were soon to proceed with their own plans. The Pembrokeshire magistrates, though, seemingly impervious to the Commissioners' comments about their asylum, had decided that they must 'avoid an increase of local taxation not imperatively demanded'. Even so, attention was focussed on combining Glamorgan with that county and those of Cardigan and Carmarthen. Innumerable meetings then took place between the representatives of the four counties. Hitch had already made recommendations regarding sites which he had visited in the western part of Glamorgan, but the joint counties' committee had no legal right to purchase land. He replied to one landowner who maintained that he had no wish to live near an asylum by saying that the ensuing turmoil 'would be far less than . . . if there were a boys' school in the same situation'. For various other reasons, such as lack of accessibility, an overcrowded locality, and property that was too expensive, several possible sites were excluded. Eventually a stretch of land near

a turnpike road, but which was sufficiently secluded not 'to destroy the privacy and retirement which a Lunatic Asylum should command', was found at the western end of the county. This would have offered the easiest possible access from the other, more distant, counties, which would be further improved with the building of a railway station in the vicinity. Therefore, by the Spring of 1848, the plans for the building of the new South Wales Asylum, which would have cost more than £30,000, were in an advanced stage of development. The Secretary of State had approved the agreement drawn up between the four counties, and information concerning the design of several other asylums had been asked for and obtained. Ever optimistic, Lord Cawdor, summed up the prevailing mood, when he said that their main problem by then would be the difficulty in getting the magistrates from all four counties together during the partridge shooting season. It was only then that the committee reconsidered their decision and decided that the site was 'unfavourable [for] a great curative hospital', as it lay on part of the south Wales coal basin. (Many of the magistrates were themselves coalowners, and it is tempting to speculate that they had only become aware of these plans at a late stage in the proceedings.)

A new situation was quickly found near the eastern boundary of the town of Swansea. At first, the landowner, Lord Jersey, decided that 'a Lunatic Asylum is by no means a desirable thing to have and must depreciate the adjoining property', but he later agreed to the purchase, on the grounds that it was in the public interest. The words of Thomas Dalton, the Clerk to the Glamorgan Quarter Sessions court and to the four counties committee, 'we must *not* shrink from a little trouble at the outset or we shall be foiled', had an ominous ring, though. The Public Loan Office, from which the money for the building would have to be borrowed, had no funds available, and this led to further delays. One of the more progressive magistrates believed that 'there are influences at work to impede if not prevent the . . . purchase', and it is certain that the Justices were far from being unanimous in the view that a county asylum was called for, even at that late stage. Leach, thought to be making excessively high profits by accepting patients from the Poor Law Unions, was still hopeful that he might be able to obtain a contract for the care of the Glamorgan pauper patients. He wrote to Thomas Dalton 'as a friend', suggesting that both landlords and tenants throughout the county believed that the whole scheme should be shelved, at least for the present. All that would be required for the Home Secretary to agree to such a course of action, he thought, was 'a proper representation of the distressed state of the agricultural interest, aggravated as it is likely to be by the bad condition of the mining interests in South Wales'. To press his case, he made it known that if the four counties were to make a contract lasting for ten years with him, a saving of £20,000 of public money might be achieved. Nicholl refused to accept Leach's argument, as his charges were too high and, in any event, 'the counties were pledged to build'.

For reasons that remain obscure, the Home Secretary did not issue a writ of *mandamus* against the south Wales magistrates, although by 1850, it was hoped that if this were to happen, they 'would be able to meet it with a sufficient answer'. By then, the dissidents among the Justices had been sufficiently placated for a contract for the purchase of the land to be signed. With the approval of the Secretary of State having been obtained and a government loan guaranteed, it seemed that nothing could interfere with the scheme. From an early stage

in the proceedings, the information given to the magistrates had included the rules which governed the selection of sites, and they had been clearly informed that they must not be 'near to any nuisances, such as steam engines, noisy trades [or] offensive manufactories'. They, in turn, had remained convinced that the new asylum would be admirably situated, and in a healthy position. The County Surveyor's report had supported this view. He had commented on the sheltered position, the unsurpassed views, the availability of stone for building, the sufficiency of the water supply, with easy access to 'good markets of fish &c.' and a nearby railway. There could, it seems, be no doubt as to the 'perfect fitness of the site for the object for which the land was purchased'.

The fact that the land was near to a copper works either seems to have escaped the attention of those concerned, or it may be that this was regarded as having been irrelevant. In April 1852, an industrialist who owned property in the district pointed out to the Lunacy Commissioners that the site was set in swampy ground, on the side of a mountain. The heart of the British copper industry was in Swansea, and whereas it was intended to pay £100 an acre for the asylum site, in his view, it was worth no more than a twentieth of that sum. 'Does Swansea', he went on, 'present any inducements . . . to erect a common asylum and hospital for madmen and idiots in the very suburb of its town and in the midst of all the smoke of its manufactories?' To complicate the issue, plans had been made to build another copper works nearby, so that it was quickly arranged for one of the medical inspectors of the Board of Health to inspect the site before any further work was done.

The inspector, Mr Grainger, arrived in Swansea in June 1852. He interviewed doctors who worked in the area and spoke to local residents, as well as examining the parish death registers and assessing the effects which any 'noxious miasmata' from a nearby bog might be expected to have. A local solicitor, who happened to be there at the time of the inspector's visit, was left with the impression that 'he seemed to approve of all but that confounded smoke'. That alone, apparently, was sufficient for Mr Grainger. He recommended that, 'on sanitary principles', the site was unsuited for an asylum. In view of the circumstances, the Commissioners and Secretary of State had no alternative but to accept that view, and Lord Palmerston, as Home Secretary agreed that compensation must be paid to the landowner.

For a time, it seemed as though this would strengthen Leach's position – as one magistrate put it, they would be unable 'to take charge of the lunatics' themselves for a considerable time after that. By then, though, these were the only Welsh counties left without their own asylum, and a site near the town of Carmarthen was thought to be suitable. Many of the Glamorgan magistrates refused to countenance the idea of a building outside their own county, so that the state of general disunity continued. Moreover, several of the Glamorgan Poor Law Unions remained unconvinced about the need for a county asylum. This was the case in Swansea, where following a public meeting in the town, it was said 'that the maintenance of the [Crimean] war together with the high price of provisions has entailed so heavy a burden on the energies of the industrial classes', that the whole matter should be dropped. The magistrates themselves failed to agree on the best solution to the problem. It was said that every resolution passed at quarter sessions meetings was capable of being reversed within a short space of time, and this state of total disarray might have continued, had it not

been for a remark made publicly by one of the more responsible among the Glamorgan magistrates. His comment that he was no longer prepared to 'leave the care of our lunatics' in the hands of the Carmarthenshire magistrates, had an inflammatory effect of sufficient intensity to put an end to the four counties' union, and the other three eventually built their own asylum (now St David's Hospital, Carmarthen).

During the time that these somewhat fruitless discussions between the counties had taken place, Glamorgan itself had become increasingly more industrialised, and there had occurred a further, larger, increase in population. Thus, the grounds for building an asylum solely for Glamorgan were unassailable. By October 1857, the Commissioners' approval had been obtained for the purchase of a farm, with 71 acres, at the centre of the county, at Bridgend. A further seven years were to pass, though, before the Glamorgan County Asylum was opened, with the excellent Dr David Yellowlees as Medical Superintendent. The Joint Counties' Asylum for west Wales was opened at Carmarthen in the following year.

It is probable that at the time of the passing of Wynn's Act in 1808, there did not exist a great deal of need for psychiatric accommodation in Wales. That view was still accepted in Glamorgan 30 years later (Davies, 1993, pp. 40-1), by which time the population of the county had doubled. Only too frequently, it is forgotten that the increased prosperity which came as the process of industrialization displaced the agrarian way of life, created new demands for services which the State was often not able to provide. There can be little doubt that the greatest hindrances to the development of a proper psychiatric service throughout Wales, and especially in Glamorgan, during the first half of the nineteenth century, were poverty among the ratepayers of the lower classes together with the intransigence of the wealthier county magistrates. In addition, it cannot have escaped the attention of many of the poor law guardians that mental illnesses were not, on the whole, life-threatening conditions. Faced as they were with a multitude of other difficulties, it is hardly surprising that they too failed to find any lasting or satisfactory solutions in this sphere. Together, these factors had ensured that psychiatric matters did not rate as highly in terms of priority as many of the other problems of the age, and it may be that the authorities of the day should not be subjected to what was once described as 'the excessive condemnation of posterity' (McCord, 1974, p. 201).

In fact, the delay in opening county asylums on a larger scale in Wales may not have been without its advantages. Much had happened in the field between the time of the 'conversion' of the gaol at Haverfordwest for the use of the psychiatrically disabled and the opening of the new North Wales Asylum at Denbigh in 1849 as well as that of the Monmouthshire Asylum at Abergavenny in 1851. The move to establish public asylums in England, already apparent in Scotland before then (Walmsley, 1991, p. 294), had gained considerable ground, and consequently, better trained medical staff eventually became available. By 1857, of the 120 members of the Association of Medical Officers of Asylums and Hospitals for the Insane, 4, including Dr Norton, were from Wales (*Journal of Mental Science*, 1857). The inception of Forbes Winslow's *Journal of Psychological Medicine and Mental Pathology* in 1848, and the *Asylum Journal* in 1853 helped, to some extent, to improve communication between asylum doctors. Of at least equal importance was the fact that the Madhouse Act of 1828 had made regular

medical attendances at asylums compulsory, and by the mid-1860s, the work of the Lunacy Commissioners as a permanent inspectorate had been in progress for about twenty years.

What little evidence is available suggests that from the mid 1850s onwards, public attitudes to asylum care may also have changed, at least in parts of Glamorgan. In some cases, relatives of patients who had died at Vernon House, Briton Ferry, were prepared to acknowledge this openly (Davies, in press, pp. 18-9). By the 1880s, the signs of prejudice which had been so prominent when the house was opened seemed to have virtually disappeared. More than 2,000 children enjoyed an afternoon playing in the asylum grounds after their Whit Monday annual procession, when they 'presented a most animated scene [and] a most enjoyable afternoon was spent'. The leadership provided by a small group of enlightened magistrates in Glamorgan had ensured that their fellows would also assume a less biased attitude to psychiatric matters by the third quarter of the nineteenth century. Prominent among those who had been quietly opposed to reform was C. R. M. Talbot, the MP for the county and Father of the House of Commons from 1874 to 1890, (who never spoke in parliament on psychiatric or any other matters for most of the time that he spent there). Yet, he and several others who had shared his views, accepted invitations to become members of the committee of management of the new county asylum from the time of its opening.

From the mid-nineteenth century onwards, this series of largely unrelated events, taken together, might be viewed as having played an important part in the eventual emergence of psychiatry as a separate specialty. Their influence helped to shape the form which the new service for the mentally disabled was to take. Indeed, by the time that this second generation of county asylums was in being, the standards of care available had already been considerably elevated. By the mid-1860s, a pattern of in-patient psychiatric care had been established for most of the population of Wales, based on the setting up of new county asylums, that was to persist until well within living memory. It was with their opening that the psychiatric past ended and the true history of psychiatry in the Principality started.

Acknowledgements

Most of the preparatory work for this paper was undertaken with the aid of a generous grant from the Wellcome Trust.

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19 Two Cheers for Psychiatry!

The Social History of Mental Disorder in Twentieth Century Britain

ROY PORTER

Contemporary history is a particularly difficult enterprise and, except for isolated islands, the social relations of modern British psychiatry remain an uncharted ocean. It has been the aim of this contribution to venture beyond 'psychiatry' in the strict medical and professional sense and to examine the fortunes and standing of a much wider range of discourses and disciplines sometimes loosely called 'psychiatric' by the public at large and including academic and pop psychology and various forms of psychotherapy. For this spectrum, the English language lacks a convenient umbrella term. The subject, taken in this wider sense, is sprawling, and if the ensuing account is superficial and patchy, it is hoped that it will at least stimulate worthier successors.

The Peculiarities of the English

Around 1900, Britain did not afford the most fertile of soils for psychiatry, either as a medical specialty or as an analysis of the self. Other centres, notably Vienna, Heidelberg, Berlin, and Zurich, were to prove in the early years of this century more propitious as social, cultural, and intellectual environments. Especially from the 1920s, with the mental hygiene movement launched and publicised by Clifford Beers, and then with the uptake of Freud, psychiatry and psychology-for-the-millions grew big in North America (Grob, 1983). In recent decades, it has been on the Pacific and Atlantic coasts of the United States, as well as in France, that the intelligentsia and the avant garde have most fervently embraced the philosophical and fashionable potential of the psychoanalytical legacy in such diverse fields as personal fulfilment, feminism, and film theory.

In contrast to such lush pastures, the Britain whose long Victorian era finally came to an end on 22 January 1901, might be seen as a badland where, for the most part, psychiatry remained something of a retarded and stunted growth and the public tended to be at best lukewarm towards psychiatries old and new alike. A memorable scene in Virginia Woolf's *Mrs Dalloway* (1925) depicts the shell-shocked Great War veteran, Septimus Warren Smith, consulting the nerve specialist, Sir William Bradshaw, evidently a bulwark of the 'old school':

Sir William himself was no longer young. He had worked very hard; he had won his position by sheer ability (being the son of a shopkeeper); loved his profession; made a fine figurehead at ceremonies and spoke well – all of which had by the time he was knighted given him a heavy look, a weary look (the stream of patients being so incessant, the responsibilities and privileges of his profession so onerous), which weariness, together with his grey hairs, increased the extraordinary distinction of his presence and gave him the reputation (of the utmost importance in dealing with nerve cases) not merely of lightning skill and almost infallible accuracy in diagnosis, but of sympathy; tact; understanding of the human soul. He could see the first moment they came into the room (the Warren Smiths they were called); he was certain directly he saw the man; it was a case of extreme gravity. It was a case of complete breakdown – complete physical and nervous breakdown, with every symptom in an advanced stage, he ascertained in two or three minutes (writing answers to questions, murmured discreetly, on a pink card).

How long had Dr. Holmes been attending him?

Six weeks.

Prescribed a little bromide? Said there was nothing the matter? Ah yes (those general practitioners! thought Sir William. It took half his time to undo their blunders. Some were irreparable). (Woolf, 1990, pp. 83-4)

Woolf presented the nerve doctor Bradshaw as a pillar of mediocrity, conformity, and complacency – a man whose supposed expertise did little more than reinforce oppressive Victorian prejudices:

Sir William said he never spoke of 'madness'; he called it not having a sense of proportion Shortly and kindly Sir William explained to [Smith's wife] the state of the case. He had threatened to kill himself. There was no alternative. It was a question of law. He would lie in bed in a beautiful house in the country. The nurses were admirable. Sir William would visit him once a week. If Mrs Warren Smith was quite sure she had no more questions to ask – he never hurried his patients – they would return to her husband. She had nothing more to ask – not of Sir William. (Woolf, 1990, p. 85)

To escape the living death of Bradshaw's proposed treatment, Septimus promptly hurled himself out of the window, impaling himself on the railings below.

If, in giving voice to Bloomsbury's self-admiring nonconformity, Woolf offered a blatant caricature of the mind doctor, it was perhaps warranted by her own unhappy encounters with such leading psychiatric physicians as Sir George Savage and Maurice Craig and her experiences of the 'rest-cure' that she was induced to undergo at their bidding, during which she had been denied access to pen and paper. She felt no compunction about thus concluding her sketch of the establishment physician with a malicious barb:

Sir William not only prospered himself but made England prosper, secluded her lunatics, forbade childbirth, penalised despair, made it impossible for the unfit to propagate their views until they too, shared his sense of proportion. (Woolf, 1990, p. 87)

Painful first-hand experience had led her to expect nothing better from 'nerve experts', and she clearly anticipated others would concur with her

critique, and sympathise with Septimus's instinct that any alternative was better (Trombley, 1981).

Woolf's vignette was, it goes without saying, highly tendentious. But it echoed a deep-rooted and heart-felt Anglo-Saxon distrust of psychiatry. It had been a tenet of well-bred Victorians that one's mind, like one's intimate body functions, should remain essentially private; matters of the heart or soul should not lightly be aired in public or meddled with by outsiders. Mental disturbances and other personal crosses were private and confidential tragedies, to be coped with domestically as best one could, with the aid of a discrete family doctor and trusty retainers.

Amongst the lower social reaches, glaring insanity would necessitate the public asylum and all its attendant shameful echoes of the workhouse. For affluent lunatics (and, increasingly in the twentieth century, with the dwindling of private asylums, that meant the very rich), there was the 'house' or 'nursing home', places deep in the country like Ticehurst (Mackenzie, 1993). State institutions imposed strict security regimes, with formal certification procedures, walls, and gates, all under lock and key; private hospitals went in for rural obscurity and genteel silences. Either way, turn-of-the-century institutions fulfilled the Victorian predilection for keeping peculiar folks within the seclusion of the family and removing full-blown insanity far out of sight.

Anglo-Saxon attitudes at large disposed the Edwardians to this less than ardent engagement with psychiatry. Self-reliance, moral earnestness and individual responsibility, combined with emotional reticence and the stiff upper lip, all reinforced by an ethos of privacy and fervent family loyalties – these enduring Victorian values, so influential amongst the respectable classes, tended to make the psychiatric doctor a person of last resort.

The professional forms psychiatry had assumed in the Victorian age also rendered it not particularly user-friendly and hence unlikely to spawn an ebullient, attractive psychological or 'psy' culture. Victorian legal and administrative developments had concentrated psychiatric practice and personnel within huge but isolated public asylums. In contrast with the German-speaking lands, university psychiatry had hardly begun to exist. Influential late-Victorian London consultants specialised more in neurology than in psychiatry proper, and, perhaps unlike Vienna and other centres, the tender buds of consulting psychiatry had been blasted by the prestige of old-style general practitioners who, committed to a pastoral role, had tended to eschew psychiatric specialisation in favour of bluff moralising common sense – a stress on exercise, diet, balance, and all the other Bradshawian bromides that Virginia Woolf debunked (Bynum 1985; Clark, 1981, 1988). With most public asylums underfunded and bursting at the seams, it cannot have been clear in the early years of the new century where psychiatry's growth-points would appear, or through which channels public interest in the psy-sciences would expand.

These negative elements are undeniable, but too bleak a picture must be avoided. Developments were taking place within psychiatry itself, for instance the founding of the Maudsley Hospital, and public interest was undeniably growing in matters of the mind on a broad front, as part of the wider hunger for science so powerful after Darwin. By 1900, Britain had achieved universal literacy, and a mass readership for science fact and science fiction was being fed by first-rate popular writers. The late Victorian waning of religion – a decline soon made

precipitous by the grotesque and unfathomable carnage of the Great War – left a yawning gap, so long filled by faith and now destined to be supplied by other philosophies, from science to spiritualism, explaining the meaning of life by reference to the mysteries of the psyche.

Science played a key role in early twentieth-century popular culture. Thanks to pre-war ‘romances’ like *The Time Machine* (1895), H. G. Wells became the bestselling writer of the age, foretelling scientific futures; to a whole generation, he represented the exciting, if terrifying future that science had to offer – the young C. P. Snow recalled avidly reading his works as they poured off the presses. Later works like *The Science of Life* (1931) and *The Shape of Things to Come* (1933) turned Wells from a success into a sage.

But it was not just Wells: all manner of other scientific works for the layman sold like hot cakes. Lancelot Hogben’s *Mathematics for the Million* (1937) was followed by *Science for the Citizen* (1938); the former – still in print – sold half a million copies in 40 years, and the latter 200,000 copies with 11 translations. Sir Arthur Eddington achieved similar success with *Stars & Atoms* (1927) and *The Expanding Universe* (1933), and he was matched by Sir James Jeans in *The Universe Around Us* (1929). *Discovery*, a monthly magazine devoted to science, was founded in 1920, while amongst the first Pelican paperbacks were Julian Huxley’s *Essays in Popular Science* (first published 1926) and Jeans’s *The Mysterious Universe* (first published 1930).

As science grew in appeal, scientists set themselves up as, or were called upon to become ethical gurus and political pundits. J. B. S. Haldane in *Daedalus, or Science & the Future* (1924) and Julian Huxley in *Essays of a Biologist* (1923) directed public attention to biology, while in *Brave New World* (1932), Aldous Huxley, Julian’s half-brother, fired a warning shot, alerting readers to the dangers of simplistic scientism (Stevenson, 1984).

At the same time, comparable expansion was occurring in the social sciences, creating an intellectual climate increasingly favourable to the promotion and popularisation of sciences of the self. Fin-de-siècle debates about human nature focused on the contested roles of nature and nurture, individual freedom, and social evolution. As epitomised by Darwin’s contemporary, John Stuart Mill, British psychological thinking had long been rooted in individualism, empiricism, utilitarianism, and rationalism; but philosophical psychology was gradually assuming both a more scientific and also a more sociological cast. Under the influence of Alexander Bain, the journal *Mind* had appeared in 1876, declaring itself ‘the first English journal devoted to Psychology and Philosophy’, dedicated ‘to procure a decision as to the scientific standing of psychology’. In 1897, James Sully established the first English experimental psychology laboratory at University College London; four years later the British Psychological Society was founded, and in 1904 the *British Journal of Psychology* appeared.

The new psycho-social theories achieving popularity early in the century laid stress upon scientific analyses of the ‘group mind’ and the social will. The idea of ‘mass psychology’ became popular. The Sociological Society committed itself to discovering the ‘underlying laws of society’, studying the ‘social mind’ and trends in public opinion, while the Eugenics Education Society, founded in 1907 by, amongst others, James Crichton-Browne, built upon Francis Galton’s statistically-based preoccupation with mental deficiency and national efficiency, claiming that the mental and physical fitness of the kingdom hinged upon

a proper understanding of race and inheritance. These and many other intellectual cliques and organisations were pursuing, each in its own distinctive way, new models of social understanding at this time (Mazumdar, 1992).

The trailblazer of academic sociology was Leonard Hobhouse (1864-1929), the first professor of sociology at London University. His *Social Development* (1924) updated theories of social evolution (and thus incorporated some of Herbert Spencer's individualism), while ensuring that British sociology continued to plough an empirical furrow by endorsing the work of social investigators like Charles Booth. It was indeed an age marked by bigger, better and statistically more refined social surveys. During a publishing career which spanned half a century, Seeborn Rowntree was to produce a succession of major social inquiries which shaped the nation's thinking: *Poverty, A Study of Town Life* (1901), *The Human Needs of Labour* (1918), *Poverty & Progress* (1941), and (with G. R. Lavers) *English Life & Labour* (1951). In 1927, A. M. Carr-Saunders and D. Caradog Jones brought out their *Survey of the Social Structure of England & Wales*, with a new edition in 1937, and in 1958 *Social Conditions in England & Wales* brought the survey up to mid-century. The better analytical and statistical grasp of the nation afforded by such surveys was to give an impetus and a sound empirical basis to the new social turn that psychiatry was beginning to take.

And as sociology pursued its explorations of social structure and social function, anthropology was meanwhile gaining great popular appeal, thanks to its exploration of the intriguing notion of the primitive mind. Bronislaw Malinowski's *Sexual Life of Savages in North Western Melanesia* (1929) put exotic sex on the map, while nearer home, the anthropological outlook pervaded Mass Observation, founded by Tom Harrisson in the 1930s with the aim of discovering the outlooks and prejudices of ordinary people (its first study appeared in 1937). Anthropology and psychology provided fresh insights into the hidden beliefs and rituals of the day-to-day world, undermining the old utilitarian model of society as a contractual club of rational self-interested individuals. This silent but inexorable revolution in the social sciences thus involved the disintegration of the old Victorian model of *homo economicus* or rational man (typically conceived to be male). Educated opinion was creating a new conventional wisdom: that humans are products of broader and deeper socio-psychological forces. This created openings and opportunities for a new psychiatry.

Small surprise, then, in these circumstances that the decades after the Great War produced an avalanche of books promoting and popularising psychology. The figure who initially captured public attention was Cyril Burt, Professor of Education at the University of London from 1913 to 1932, and subsequently Professor of Psychology, whose theories of intelligence and intelligence-testing achieved high profile, seeming to chime with meritocratic educational thinking and faith in social mobility in the era of mass democracy. In a series of publications - *Mental & Scholastic Tests* (1921), *The Subnormal School Child* (2 vols, 1925 and 1935), *How the Mind Works* (1933), *The Backward Child* (1937), *The Factors of the Mind: an Introduction to Factor-Analysis in Psychology* (1940), *The Gifted Child* (1975) and others - Burt demonstrated the relevance of psychology to social problems and individual development.

After the Second World War, the psychological mantle was assumed by the German-born Hans Eysenck, who achieved great public renown with a cascade of works exploring intelligence and learning, and explaining personality types.

In the intellectual tradition of Galton and Burt, books like *Dimensions of Personality* (1947), *The Scientific Study of Personality* (1952), *The Structure of Human Personality* (1953), *Crime & Personality* (1964), *Smoking, Health, & Personality* (1965), *The Biological Basis of Personality* (1967), *Sex & Personality* (1976) – some written for his peers but many for the public at large – offered an appealing psychology which combined science, self-knowledge, and personal betterment (Woolridge, 1994).

The years after the Second World War brought a vogue for do-it-yourself pop-Freudianism, exemplified by works like Eric Berne's *Games People Play* (1964). Berne appealed to the public desire to understand themselves by offering a racy account of the psychopathology of social interactions; he presented handy advice for handling them better, based on three personality types: Parent, Adult, and Child. In his simple dynamic model, almost all personal interactions could be analysed in Parent-Child, Adult-Adult, Adult-Child terms. Overall, new ways of understanding the personality and its problems were thus being offered to the public: old-fashioned religious, moral, and material principles were replaced by new psychological categories. The most signal example of this was the reception of psychoanalysis.

The Discovery of Psychoanalysis

On Freud's death in 1939, W. H. Auden remarked in a phrase destined for immortality that he was 'no more a person now but a whole climate of opinion' (Auden, 1948). Auden was right, though the Freudian climate of opinion had met, and long continued to encounter, doughty resistance in Britain, not least amongst professional psychiatrists. Awareness and acceptance of psychodynamics grew by fits and starts.

It has sometimes been assumed that there was little interest in Freudian psychoanalysis until the shell-shock crises of the Great War created recognition of more to that condition than met the conventional eye – at least in the advanced special hospitals at Maghull (near Liverpool) and Craiglockhart (outside Edinburgh). If battle-shock was not an organic condition but a psychological malaise, it was not automatically to be interpreted as symptomatic of poor character or even cowardice. Shell-shock no doubt constitutes a major story that cannot be retold here (Merskey, 1991; Brown, 1988), but it was not the first or even the prime channel for the assimilation of Continental psychoanalytical thinking. Familiarisation with Freud was under way before the War, both at the professional level and amongst the public. For doctors, knowledge obviously came through the medical literature, but two pioneering individuals proved particularly significant in spreading the gospel: Ernest Jones and David Eder. A founder of the London Society of Psychoanalysis (1913) – reborn in 1919 as the British Society for Psychoanalysis – Jones, son of a coal merchant employee, became a close friend of Freud (and later his biographer), casting himself with characteristic egoism in the role of psychoanalytical evangelist to the heathen. In 1912, he brought out the first book published in England in this field: *Papers on Psycho-Analysis*. His ebullient personality, vanity, and extraordinary energies made him a born proselytiser. Jones relished having to tussle with what he regarded as the intense early professional hostility to the new psychoanalytical movement – and to himself. In his view, neurological science in England was so powerful as to be able to stamp

on dynamic psychiatry, while the sway of organic medicine and the obsession with diagnostics meant that mainstream British psychiatry was doggedly preoccupied with institutional confinement (Jones, 1959; Brome, 1982).

David Eder also proved an energetic evangelist. A man of many parts - as a socialist he had taken part in the Bloody Sunday riot (1887) in Trafalgar Square, which left his head scarred - Eder graduated from St Bartholomew's in 1895; a founder member of the London Labour Party, he was active in medicine for the masses. Becoming converted to Freud, he addressed a paper in 1911 to the Neurological Section of the British Medical Association on a case of hysteria and obsessional neurosis treated by Freud's method: at the end of his talk, the entire audience, including the Chairman rose and, by all accounts, walked out in icy silence. In 1912, Eder set up in private psychiatric practice, shortly afterwards migrating to Vienna for three weeks of analysis and later being analysed by Jones himself.

Two swallows hardly make a summer, however, and the British medical community as a whole long remained extremely guarded towards psychoanalysis. Professional objections were commonly expressed within the framework of the influential instinct psychology expounded at Oxford by William McDougall, notably in his *Introduction to Social Psychology* (1908); a chapter added to subsequent editions mounted a specific critique of Freud's teachings. Sex, argued McDougall, was not the *primum mobile* but only one of eleven instincts: Freud's thinking was thus wilfully reductionist, collapsing quite distinct impulses into the catchall category of the sexual. Reservations similar to McDougall's were expressed in A. G. Tansley's *New Psychology* (1920), as well as in *Instinct & the Unconscious* (1920), written by the esteemed Cambridge psychologist and anthropologist, W. H. R. Rivers. Together with William Brown, H. Crichton Miller, and a number of other eclectics, such establishment figures were generally thought to be psychologically level-headed, by contrast with the 'unscientific immoderacy' of the supposedly zealous and dogmatic Freudians.

Particularly with the peaking of anti-German feeling during the First World War, psychoanalysis also had its more shrill opponents, including the elderly Charles Mercier, a one-time colleague of Hughlings Jackson, who judged with gloating *Schadenfreude* that:

psychoanalysis is past its perihelion, and is rapidly retreating in to the dark and silent depths from which it emerged. It is well that it should be systematically described before it goes to join pounded toads and sour milk in the limbo of discarded remedies. (Mercier, 1916)

Psychoanalysis, he concluded, was the latest manifestation of 'the rottenness of German teaching in mental disease', and analysts were in the business of seducing children and destroying morality (charges destined, like Halley's comet, to return at regular intervals). In his 'Notes on Psychoanalysis and Psychotherapy', Sir James Crichton-Browne offered similarly forthright views and predicted that Freudianism 'will, I feel sure, never take root in this country' (Crichton-Browne, 1920: 1248).

The lay public proved more receptive: in the 1910s the number of publications containing mentions of psychoanalytical matters was increasing, and the press pricked up its ears. In 1919, it was reported that interest in psychoanalysis was

'now growing by leaps and bounds'; Freud's books, grumbled the *Saturday Review*, were now 'discussed over the soup with the latest play or novel', while 'every moderately well-informed person now knows something about Jung and Freud'. This was perhaps not surprising: in 1921, 23 different magazines printed nearly 100 psychoanalytical pieces between them, while between 1921 and 1925, popular magazines carried 400 items with significant psychoanalytic content, four of the authors being members of the British Psycho-Analytical Society (Rapp, 1988, 1990; Ellesley, 1995).

The quality press was more welcoming towards Freud than was the medico-psychological community. Popularisers seized upon his theory of the unconscious, stressing its value in the quest for self-knowledge. Yet Fleet Street remained rather selective in its approval, most journalists disparaging Freud's libidinal theories and claiming that they exaggerated the role of sex, and hence were 'repugnant to our moral sense'. While admitting that sex 'plays an enormous part in our psychology', mainstream writers maintained that Freudians were engaged in an 'exclusive worship of the sex instinct'. They tended to be sympathetic to Freud's theory of the dynamic unconscious and to his stress on socio-psychic conflict, while rejecting his determinism, downplaying his sexual preoccupations, and applauding 'healthy' moral and social values. Jung's views received a wide and warm acceptance, because they were relatively easily accommodated within traditional religious, moral, and spiritual values.

Though psychoanalysis thus met quite stout medico-psychological resistance, its tenets began to filter into cognate disciplines. By 1914, psychoanalytical papers had been delivered to the Sociological Society, the Aristotelian Society (a philosophical society founded in 1870), and the Child-Study Society, which had been set up in 1896 to promote the study of feeble-mindedness. Its ideas appealed especially to professional educators, who argued that the new doctrines provided parents and teachers with unique insights into children, yielding both deeper understanding of unconscious urges and insight into problems like bed-wetting, nail-biting, and thumb-sucking – henceforth to be understood not as mere naughtiness but as symptoms of unconscious conflicts. Sympathetic educators suggested, on psychological grounds, that sparing the rod might be essential for the child's emotional welfare.

Freudian sexual ideas also began to take root amongst the bohemian fringe and advanced intellectuals. The key figure was Havelock Ellis, whose *Studies in the Psychology of Sex* appeared in multiple volumes between 1897 and 1928. Ellis achieved widespread respect, partly because he was medically qualified, and in the early days both Jones and Freud sought his support, though later they both turned against him (Brome, 1982).

Influential as a talking-shop was the British Society for the Study of Sex Psychology, founded in 1914. It attracted a cross-section of intellectuals and prominent people interested in the study of sexual phenomena, in particular those seeking greater sympathy for the dilemmas of the homosexual, along with divorce-law reformers, sex educators, Malthusians, feminists, and social hygienists, most of whom had acquired a smattering of Freudian beliefs. Over a span of 30 years, lectures were given to it on a broad assortment of topics, including co-education, obscenity, sexual ethics, sexual crime, birth control, divorce, eugenics, homosexuality, children, intersexuality, psychoanalysis, adolescence, and sexual technique. The Society also published a succession of pamphlets,

including Stella Browne's *Sexual Variety & Variability among Women* (1917) and Havelock Ellis's *The Play Function of Sex* (1921) (Hall, forthcoming).

The practice of psychoanalysis gained a foothold, which in time turned into a foothold, and finally became an established niche: a number of private surgeries and clinics appeared. The psychoanalytical presence was enhanced by the founding of the Medico-Psychological Clinic of London in 1913 by Dr Jessie Murray, a graduate of the Royal Free Hospital who had studied in Paris under Janet. In 1913, she opened a clinic in Endsleigh Street, Bloomsbury, using this novel therapeutic technique to treat functional nervous disorders. On moving to Brunswick Square, this became known as the Brunswick Square Clinic.

A milestone was the founding in 1920 of the Tavistock Square Clinic by Hugh Crichton-Miller. Chiming with the aims of the 'mental hygiene' movement, which viewed psychiatry's agenda in terms of the mental health problems not just of the insane but of the man and woman in the street, the Tavistock approach became especially important in heightening awareness of family psychodynamics and childhood problems. Its Children's Department, opened in 1926, boosted the child guidance movement, which was to acquire institutional form in the Child Guidance Council (1927), through which emotional lives – kept so private in the Victorian era – were to become objects of routine professional inquiry and expert direction (Dicks, 1970).

Despite its success, the Tavistock never received academic recognition from the University of London, owing partly to the resistance of Edward Mapother, Professor of Psychiatry at the Maudsley Hospital, who feared competition. But it was to enjoy an enviable reputation, particularly because of the later work of John Bowlby on maternal deprivation and to its promotion of object relations theory associated with Melanie Klein.

Though psychoanalysis became naturalised into British culture in the course of time, feelings towards it remained mixed. As the literary *avant garde*, the Bloomsbury circle offers a revealing litmus test of such ambivalent responses. Its initial intellectual mentor, the philosopher G. E. Moore, pursued a style of introspection that privileged rational consciousness. Sceptical about psychoanalytical models of the mind, he believed emotions could and should be controlled, schooled, and civilised. Bloomsbury grew more receptive to Freud's work through Leonard Woolf, who reviewed Freud's *The Psychopathology of Everyday Life* in 1914. James and Alix Strachey became psychoanalysts in the early 1920s, and they were followed by Virginia Woolf's younger brother, Adrian, and his wife, Karen. Leonard Woolf's Hogarth Press became involved with psychoanalytical publishing through Ernest Jones and James Strachey. The Press was to launch the 'International Psycho-analytical Library', leading eventually to the monumental *Standard Edition* of Freud's work, occupying James and Alix Strachey for over a quarter of a century.

Yet despite such lively interest, Bloomsbury overall spurned what it suspected to be the deterministic and reductionistic tendencies of psychoanalysis, especially as applied to writing, art, and aesthetics. Roger Fry and Clive Bell publicly challenged psychoanalytical doctrines, and Virginia Woolf herself was as wary of psychoanalysis as she had been of the old nerve doctors, distrusting it as simplistic and mechanistic; it was an insufferable intrusion into personal privacy, and the Freudian pathologising view of the artist as a neurotic posed a threat to literary creativity.

By the 1930s, however, the reception of psychoanalysis, albeit in a watered-down form, was becoming more visible and pervasive in the public mind. Terms like 'nervous breakdown', 'ego', 'inferiority complex', 'repression', and 'sadism' passed into common speech. Applied psychoanalysis and intelligence-testing became increasingly influential in baby-care manuals and child-rearing. In the Second World War, an important feature of armed forces recruitment lay in the use of psychological tests for officers, and a more sophisticated awareness was shown by the Army Medical Service of the psychological stresses of battle.

The spread of Freudian notions led to the idea gaining ground – it became reputable between the Wars and conventional by the 1950s – that ordinary people might have 'complexes', and that neuroses ran like a watermark through the population at large: juvenile delinquency, housewife blues, family conflicts, alcoholism, adjustment problems, generational tensions, etc. By the 1950s, popular psychological culture had created new and exciting psychological images like the 'crazy mixed-up kid' – the more modern and down-market version of the melancholy poet or the Romantic genius. The glamourisation of madness by the anti-psychiatry movement lay just around the corner. When, in the early 1970s the poet Philip Larkin wrote:

They fuck you up
Your mum and dad (Larkin, 1974)

the Freudian reverberations of the sentiment would have been lost on none. If, as argued at the outset of this essay, the Victorian legacy had left Britain somewhat 'different' in its psychiatry and attitudes towards psychiatry, by mid-century, Britain had clearly joined the European and North Atlantic psychiatric mainstream.

The Discovery of the Neurotic Nation

The establishment during the nineteenth century of a comprehensive system of public lunatic asylums had ambiguous implications. It vastly increased the perception of insanity – the grid of grey, grim, walled institutions testified to what was widely called an epidemic of madness in modern industrial society. And yet, by sequestering the mad, the policy of 'compulsory psychiatry', with its certification procedures and legal safeguards, had in effect given Victorian society at large (the same could be said for French or German society) a clean bill of health: could not all those who had *not* been consigned to the asylum be taken as rational and mentally sound?

The drift of twentieth-century developments, by contrast, has been to challenge and dissolve such reassuringly obvious, black-and-white distinctions. This has in part been due to changing psychiatric theories. But it has not least been because society itself has been recognised to be growing more fluid, mobile, confusing. Clear-cut polarised ideas of 'two Englands' had enjoyed wide currency in the Victorian era: industrial and rural, North and South, rich and poor, male and female. Later perceptions of a new and baffling complexity were put into a nutshell by the popular writer, J. B. Priestley, whose *English Journey* (1934) identified not two but three Englands:

There was, first, Old England, the country of the cathedrals and minsters and manor houses and inns, of Parson and Squire; guide-book and quaint highways and byways England.

Then, I decided, there is nineteenth-century England, the industrial England of coal, iron, steel, cotton, wool, railways; of thousands of rows of little houses all alike, sham Gothic churches, square-faced chapels, Town Halls, Mechanics Institutes, mills, foundaries, ware-houses, refined watering-places Literary and Philosophical Societies, back-to-back houses, detached villas with monkey-trees, Grill Rooms, railway stations, slag-heaps and 'tips', dock roads, Refreshment Rooms, doss-houses, Unionist or Liberal Clubs, cindery waste grounds, mill chimneys, slums, fried-fish shops, public houses with red blinds, bethels in corrugated iron, good-class drapers' and confectioners' shops, a cynically devastated countryside, sooty dismal little towns, and still sootier grim fortress-like cities. (Priestley, 1934: 397-9)

But another England had also been growing up alongside these, Priestley argued, one that had few roots in Old England or in the old class certainties – one marked by a kind of American rootlessness, both physical and psychical

belonging far more to the age itself than to this particular island. America, I suppose, was its real birth-place. This is the England of arterial and by-pass roads, of filling stations and factories that look like exhibition buildings, of giant cinemas and dance-halls and cafés, bungalows with tiny garages, cocktail bars, Woolworths, motor-coaches, wireless, typing, factory girls looking like actresses, greyhound racing and dirt tracks, swimming-pools, and everything given away for cigarette coupons. (Priestley, 1934: 401)

Society itself was thus in flux. The interwar mix of Depression and new affluence was eroding old certainties and creating fresh predicaments, not least amongst those living near the new arterial roads. And new theories associated with public health and social medicine were eating away at traditional distinctions between the healthy and the sick, the rational and the crazy. Such pigeon-holing, it was now commonly argued, had been far too crude, and broader experience – in part, the revelations of the social surveys just discussed – was revealing the true extent and intricacy of social pathology. Mass-schooling (universal and compulsory after 1870) highlighted learning and personality disabilities amongst children, and posed the problem of their treatment. The ghastly experience of the Great War had likewise revealed psychological defects in apparently fit soldiers. In many quarters and with varying emphases, the rising mental hygiene programme, promoted by the National Council for Mental Hygiene, founded in 1922, promoted the notion that problems and disorders of the man-in-the-street, hitherto latent and undetected but all too real, deserved assistance no less than the psychoses of the institutionalised. For all these reasons, a concern with mental health began, slowly but decisively, to percolate beyond the asylum walls into the very pores of society at large.

And this in turn created profound problems and divisions over policy. As more backward children, 'abnormals', and borderlines were discovered, powerful arguments were voiced in some quarters for segregating larger numbers and additional categories of social defectives. Such concerns had a lengthy history. At the close of the nineteenth century, social reformers like Charles Booth

had argued for labour colonies for the lumpenproletariat; both the Minority and Majority Reports on the Poor Law (1909) recommended colonies for the jobless to replace a workhouse system that had never solved the problem of idleness. In the light of such developments, plans for further settlements for the mentally 'deficient' won wide appeal. Others, however, opposed strategies of removing problem people, arguing that the appropriate course of action was to readjust them to society – and perhaps at the same time to reform society itself.

Controversies regarding how to handle problem people surfaced early in the proceedings of the Royal Commission on the Care & Control of the Feeble-Minded, set up in 1904. The Commission proved receptive to the ideas of the Eugenics Education Society, a lobby led by prominent members of the social and intellectual elite, notably Leonard Darwin, Charles Darwin's son, whose influence was out of all proportion to its rather diminutive numbers. Convinced that nature counted for more than nurture, type rather than environment, and horrified by ostensible evidence of mounting national unfitness, the Society argued that the physical and psychological health of the nation was to be safeguarded not by Lloyd George-style social reform (better social services, better housing, nutrition, and public health) but by improving the national stock. Programmes of positive eugenics would encourage the upper classes to have larger families, while negative eugenics should be utilised to reduce the breeding propensities of inferior strains and degenerates. Few English eugenisists were enthusiasts for compulsory sterilisation, except in extreme cases, but many saw the segregation of the unfit as an effective means of preventing undesirable procreation. Though eugenists mainly came from the political Right, the Society's ideology of scientific social engineering also found favour with some experts and ideologues on the Left, anxious for the end of *laissez-faire* and for greater planning for the future; for various Fabians, selective breeding was part and parcel of a much-needed application of science to social policy. 'The legitimate claims of eugenics', pronounced the *New Statesman*, 'are not inherently incompatible with the outlook of the collectivist movement' (Thomson, 1992, p. 495).

Urging the implementation of the Report of the Royal Commission (1908), a pamphlet issued by a joint committee in support of the Mental Deficiency Bill, which included the Archbishops of Canterbury and York, bishops, doctors, clergy, and members of the House of Lords argued that action was necessary

BECAUSE at the date of the Report of the Royal Commission, there were 279,000 mentally defective people in England and Wales, of whom 149,000 are uncertified. There is for them no recognised and generally no possible means of control, although they are totally incapable of managing themselves or their affairs . . . BECAUSE in consequence of the neglect to recognise and treat their condition, the mentally defective become criminals and are sent to prison; they become drunkards and fill the reformatories; they become paupers and pass into the workhouses. BECAUSE they are frequently producing children, many of whom inherit their mental defect, and nearly all of whom become the paupers, criminals and unemployables of the next generation. (quoted by Rose, 1985, p.108)

The result was the Mental Deficiency Act (1913), which represents the peak of the influence of the Eugenics lobby. In line with the Committee's insistence

that investigation 'must extend to children of all grades of mental defect' and defective adults as well, the Act of 1913 required local education authorities to ascertain all mentally defective children between the ages of 7 and 16. Responsibility for furnishing them with special education was established in the Elementary Education (Defective & Epileptic Children) Act of 1914. School teachers were required to provide names of defectives; those beneath school age were to be identified by voluntary agencies, child welfare clinics, health visitors, and district nurses, and to be visited in their homes. By implication, the entire nation would in the future be surveyed for mental deficiency – an unprecedented extension of psychiatric, psychological, and eugenic concerns to the whole population (Armstrong, 1983).

But once problem people had been identified, what then should be done? Conflicts raged over the options. Supporters of the 1913 Act argued that removal of defectives from the community was necessary in the interests of national efficiency – so as to prevent criminality, idleness, and the multiplication of low-grade types. It was important, they believed, to protect the defective from the community and the public from defectives, in particular sexually promiscuous women of low intelligence who were allegedly burdening the nation with their substandard offspring. Opponents counter-argued that what would be really insufferable were the costs of such vast colonies (see also Chapter 7, this volume).

It was, however, further confinement that initially won parliamentary endorsement and became translated into public policy: alongside the traditional public asylums for the insane, first established after the Act of 1808, new colonies for defectives were set up. Such 'homes for idiots' were originally envisioned in the light of the idealistic educational visions of the French educator, Edouard Seguin. In time, however, education and organisation in such colonies became directed less toward rehabilitation than to turning the substandard into useful members of the settlement community. At her high-profile Sandlebridge Colony near Manchester, Mary Dendy aimed for this goal through a regime of rewards and punishments directed simultaneously at moral reform and managerial order. 'Idleness means degradation of the lowest kind for the feeble in intellect', she pronounced, insisting:

There is no other way but regular work, which leaves the children so tired at night that they go to sleep when they go to bed, to keep them falling into habits which further lower the already low intelligence and physical strength. (Quoted by Thomson, 1992, p. 484)

Segregation was a holding operation. But was the nation itself truly healthy? This oft-posed question prompted later efforts in the interwar years to gauge the incidence of mental disorders in the community at large – an emphasis increasingly falling upon neuroses not severe enough to warrant hospitalisation or certification but nevertheless considered to be endemic. In 1934, believing it 'important to form some estimate of mental disorder as a whole', since there were 'no figures available in England', the psychiatrist Eliot Slater published a paper on 'The Incidence of Mental Disorder'. A further study followed in 1943, based on admissions between 1939 and 1941 to a war-time emergency hospital, while a subsequent attempt to examine a population was published by

the Director of Clinical Research at Crichton Royal Hospital, Willy Mayer-Gross (1948-9). Earlier surveys had tended to deal only with abnormal populations, but 'during the last 30 years', Mayer-Gross tellingly noted, pinpointing a trend, 'the interest of psychiatry has shifted from the major psychoses, statistically relatively rare occurrences, to the milder and borderline cases, the minor deviations from the normal average'. Psychiatry needed to become properly informed about such apparently new patterns of morbidity.

Psychiatric attention was thereby being extended to 'milder' and 'borderline' cases, and mental abnormality began to be seen as part of normal variability – there were parallel extensions of special facilities for other segments of the population, for instance 'delicate' children. A new social psychiatry was thus in the process of being formulated, whose purview extended not, as in the enclosed asylum, over a clearly-defined abnormal group but over an entire populace. The implied blurring of the polar distinction between sane and insane was to have momentous practical consequences for custody and care. As emphasis tilted from institutional provision *per se* to the clinical needs of the individual patient, it pointed in the direction of promoting the 'unlocked door', outpatient clinics, day hospitals, and unrestricted visiting, with an emphasis on early discharge. The RMPA's *Memorandum on the Future Organisation of Psychiatric Services* (1945) significantly commented that 'where psychiatry begins and ends has not been settled', for the boundary between the normal population and the neurotic was growing somewhat grey.

Such developments presaged the waning of the asylum era. In the 1944 revision of their *Textbook of Psychiatry for Students and Practitioners* (first published in 1927), D. K. Henderson & R. D. Gillespie added a section on the 'Social or Community Period'. In tune with the spirit of the times, they advocated the extension of mental health concern and psychological skills into the community: attention must be paid to the proper training of those running nurseries, residential schools, and youth centres – to say nothing of the need for heightened awareness of mental health amongst general practitioners – a cause soon to be associated with the campaigns of Michael Balint (Balint, 1957; Osborne, 1994).

The mental health searchlight thus began to be trained beyond the closed hospital onto the wider world, and this required the seeding and posting of more psychiatrists and psychological specialists within society at large. From interwar times, and even more after 1945, psychiatric and psychological expertise began to be deployed in certain administrative situations. Psychological personnel and techniques became involved in the testing of individual conduct and the handling of personal problems in the armed forces, in job applications and selection for employment, and in hospitals, schools, and prisons. Aptitude and intelligence testing became routine, and new psychological specialisms gained ground – clinical psychology, criminal psychology, educational psychology, industrial and military psychology.

This gradual but significant planting of people with psychiatric or psychological training in posts of social influence – in education and employment, in the law courts and the probation services, in the armed forces and in industry – represented at least a partial fulfilment of the aims of the mental hygiene lobby, articulated through the National Council for Mental Hygiene, founded in 1922 under the patronage of the great and the good. Paralleling the crusade for mental hygiene launched by Clifford Beers in the USA, the

British neo-hygienist movement promoted mental health as both a personal responsibility and a social duty. From the first Report of the Board of Control after the First World War and the Report of the Royal Commission on Lunacy & Mental Disorder (1926), down to the Report of the Feversham Committee on the Voluntary Mental Health Services (1939), the philosophy of mental hygiene became incorporated into official thinking. There was, for instance, a typical assumption of links between mental disturbance and 'socially inefficient conduct' – criminality, sexual deviancy, and wilful unemployment – which helped to sanction the new preventive medicine of mental hygiene and later of 'social medicine'. If mental illness might be distinguished as a root-cause of all manner of social inefficiency, then unemployment or criminality might be said to have more psychological than economic or political causes. And it was now argued that mental disorders could be averted by the promotion of correct family habits of mental hygiene, as well as by early detection and treatment (Rose, 1985; Ellesley, 1995).

Though facing resistance from traditionalists, the mental hygiene movement aspired to extend psychiatric and psychological teaching to all theatres of society. In the case of child crime, for example, mental hygiene experts now argued that magistrates should not deal with delinquents on the banal basis of their illegal deeds but in the light of the deeper springs of their psychopathological behaviour. What teenage offenders principally needed was not punishment but correction – tailor-made schools and rational schemes of probation. Above all, what was needed was *understanding*, and so it was the task of juvenile courts to assemble expert information. The local education authority was required to provide data about the 'problem child's' school career and medical record; probation officers were to inquire into home and family background; and delinquent children were to be kept in special remand homes, where they could be properly observed before being dealt with by the courts.

All such prescriptions (rarely systematically put into effect) were given intellectual underpinning by the writings of the highly influential Cyril Burt. His *The Young Delinquent* (first published in 1925 and passing through four editions), systematised the underlying reasoning about juvenile crime, backing it with the conclusions of an inquiry into some 200 cases. In that book and elsewhere, Burt created a new psychology, conceived in terms of the range of emotional traits present throughout a population and utilising statistical techniques as part of a project to build a scientific psychology of the individual. To this end, he devised many new procedures, including word association tests – a technique first developed by Galton but improved by Carl Jung. Jung had observed delay in response to certain words, coupled with various 'indicators' of 'repressed complexes' – blushing, coughing, sighing, stammering, etc. Burt appropriated such techniques with a view to the study of personality types, especially amongst children.

In the inter-war years, routine psychological examination of children was urged not only by Burt but also by the National Council for Mental Hygiene, the People's League of Health, and the Juvenile Organisations Committee, while the Tavistock Clinic began to offer free advice to the London courts. In these and similar respects, a new psychological empire emerged, first on paper and then gradually in actuality, with similar developments occurring in family therapy, in marriage guidance, and in employment. Such developments

had major consequences for attitudes and policies. In the 1940s and 50s, under the authoritative influence particularly of Donald Winnicott and John Bowlby, much faith was vested in the nuclear family, centred on the full-time mother, as the sheet anchor of psychosocial adjustment. The consequences ranged from the introduction of family allowances to a welter of child-care manuals addressed to parents.

Since the close of World War II and spurred by Eysenckian clinical psychology, there has been a remarkable growth of additional psychotherapeutic services within what has been called the 'therapeutic society'. Nowadays, a multitude of advisory bureaux and clinics, both public and private and representing innumerable theoretical persuasions, give guidance for all conceivable defects, phobias, obsessions, and psycho-social problems – from sexual identity to eating disorders, from smoking to assertiveness-training. There has taken place what Nikolas Rose has termed the 'psychologization of the mundane' (Rose, 1990). Problems traditionally regarded in the past as religious, moral, or pragmatic have now been given additional psychological dimensions – hence, for instance, the provision of 'counselling' for victims of disasters. Through this spread of the psychological and the therapeutic, the material world was reconceptualised into a subjective, personal order (typified by anxieties, denials, repressions, or lack of psycho-social skills), liable to be attended by similarly subjective consequences: neurosis, tension, stress, illness. These new behavioural ideals, attested by the bulging 'Personal Development' departments in all bookshops, may be viewed as the ultimate implementation of the agenda of the mental hygiene movement launched in the inter-war years (Rose, 1985). Such trends, though, are now widely denounced from the political Right as encouraging dependency and the abdication of personal responsibility.

The psychiatrisation of everything occurred first in the United States. It was a trend deliciously mocked in Stephen Sondheim's lyrics to *Westside Story* (1956). The crazy-mixed-up young New Yorkers taunt the police officer on the warpath:

Officer Krupke, you're really a square;
This boy don't need a judge, he needs an analyst's care!
It's just his neurosis that oughta be curbed,
He's psycholog'ly disturbed.
We're disturbed, we're disturbed, we're the most disturbed,
Like we're psycholog'ly disturbed.

It was, as have been seen, only a matter of time before such choruses grew in volume across the Atlantic.

The Closed Asylum and its Enemies: Community Care

The twentieth century – that century of massive change – thus brought marked shifts in the aims and orientations of the mental health movement and attendant psychiatric services. At first, these amounted to little more than critical ideas and positive ideals. But they were in due course to have dramatic consequences for those imperial citadels of Victorian psychiatric policy, the ancient but increasingly shabby public mental hospitals. Their fate was to be decided against

a backdrop of broader socio-political change, involving the final replacement of those Dickensian monuments of Victorian social policy, the Poor Law and its feared workhouses, thanks to the creation of the new welfare state by the Labour Government of 1945. Such innovations had been spurred by crises and improvements alike. The 1930s brought mass unemployment: in January 1933 there were almost three million recorded as without work – totals then regarded as shocking, though they were to become routine with the high-unemployment, low-wage, anti-trade union policies pursued in the 1980s by Mrs Thatcher's administrations (Gilmour, 1992). The Depression of the 1930s and the sacrifices of World War II together dictated the implementation of the Beveridge Report, which included, amongst its welfare provisions, the final eradication of the vestiges of Victorian punitive social institutions. Most likely, once Beveridge's welfare state had exorcised the ghost of the workhouse, its sister institution, the vast public asylum with its undertones of pauperism, was doomed sooner or later to disappear.

But if the second third of the twentieth century was to bring a decline in the salience of the giant psychiatric institution, that change certainly did not entail any withering away of psychiatry itself. Far from it: there was to be marked and continued growth in the numbers receiving psychiatric treatment. Until the early 1950s, this took the form of a growth in residential psychiatric beds; first admissions to psychiatric hospitals continued to rise right up to 1970, and there has been continuing expansion in the numbers attending psychiatric clinics and the day-hospitals that began to be set up in the 1950s. There has thus been a changing pattern of mental health services, mirroring the shift, after the War, from preoccupation with severe conditions towards a new emphasis upon illnesses that many believed – though mostly without firm evidence – were growing more widespread: depression, phobias, alcoholism, substance abuse, and personality problems.

Yet controversy over the asylum is nothing new; it dates back almost to its first inception. Amongst its critics was the National Association for the Promotion of Social Science (founded in 1856 by a mixture of philanthropists, statisticians and reformers), which pondered as early as 1869 whether:

we cannot recur, in some degree, to the system of home care and home treatment; whether, in fact, the same care, interest, and money which are now employed upon the inmates of our lunatic asylums, might not produce even more successful and beneficial results if made to support the efforts of parents and relations in their humble dwelling If only one-twentieth of inmates of our asylums could by any machinery whatever, be restored to their relations, we should have strengthened the bonds of family affection and enlarged the sphere of individual liberty. Moreover, such a mode of treatment would form a fitting extension of the non-restraints system. (Busfield, 1986, p. 339)

At roughly the same time, the asylum superintendent, John Arlidge, was concluding that 'a giant asylum is a giant evil' (Arlidge, 1859, p. 102). The question of asylum reform continued to feature on the agenda, fired by criticisms (by doctors, patients, and campaigners alike) of the defects of Victorian legislation. In order to eliminate abuses and safeguard personal liberties, the influential 1890 Lunacy Act required asylums to take only legally certified patients; and

this, critics argued, hindered early treatment of mild cases, discouraged doctors and relatives from utilising facilities, and turned asylums into ghastly fortresses of incarceration. Deficiencies in the day-to-day management of asylums were also widely exposed, culminating in the damning indictment of neglect and cruelty contained in Montagu Lomax's *The Experiences of an Asylum Doctor, with Suggestions for Asylum & Lunacy Law Reform* (1921), a work that had to be taken seriously since it was written not by a protesting patient but by a disillusioned asylum doctor.

In 1918, the Board of Control (successor under the Mental Deficiency Act [1913] to the Commissioners in Lunacy) published a report which accepted the case for the introduction of voluntary asylum admission and called for provisions for early treatment and after-care (incidentally, the first official use of the term 'community care' surfaced in the Board's 1930 Annual Report). A bill proposing such changes, introduced in 1922, failed to get through Parliament, but the Mental Treatment Act (1930) belatedly instituted voluntary status, specifying three types of admission: voluntary, temporary, and certified. 'Any person', it was stated, 'who is desirous of voluntarily submitting himself to treatment for mental illness and who makes a written application for the purpose to the person in charge, may without a reception order, be received as a voluntary patient'. Such patients could discharge themselves by giving 72 hours' notice. Subsequent to the 1930 Act, two movements gathered steam, in many ways complementing each other yet pulling in diametrically opposite directions: the goal of further reforming the mental hospital, to render it as perfect as possible, and the aim of abolishing it altogether.

The 1930 Act – which renamed asylums 'mental hospitals', amongst other changes of terminology – helped change perceptions of those institutions and their relation to the community. With medicine itself rapidly advancing, thanks to sulpha drugs and, from the 1940s, antibiotics, therapeutic optimism rose, and with it the desire that psychiatry should cease to be a Cinderella, but should be integrated within the progress and prestige of general medicine. The establishment of the National Health Service (1948) furthermore brought about the administrative and financial consolidation of the mental health services within the health services as a whole (Webster, 1991).

Rising expectations produced mounting criticism of traditional asylums on the grounds that they were stultifying as therapeutic environments. The new critics – typically medical superintendents – highlighted the harmful psychological repercussions of long-term hospitalisation ('institutional neurosis'), advocating policies and therapeutic interventions designed to rehabilitate chronic patients and reinstate them within the population at large. From the late 1940s mental hospitals like Dingleton, Mapperley, and Warlingham Park opened their doors. Around the same time, 'therapeutic communities' were set up, distinct units of up to 100 patients within the larger hospitals, in which doctors and patients cooperated to create more positive therapeutic environments, eroding traditional authoritarian hierarchies between staff and inmates. A therapeutic community designed for the rehabilitation of those with personality disorders was established at Belmont Hospital by Maxwell Jones, ushering in ideas of shared and more democratic decision-making and an increasingly permissive atmosphere (Jones, 1983) (see Chapter 29).

A more radical proposal also began to be taken up, that of 'community care',

involving discharging patients from institutions altogether. The implementation of this policy has sometimes been explained in terms of the introduction in the 1950s of psychotropic drugs, but it seems that the new drugs did not so much inaugurate as expedite the practice.

In truth, by the mid-twentieth century a growing number of psychiatrists, boosted by outside critics, no longer viewed the hospital as the ideal, desirable or even a viable locus of treatment. Members of Parliament were instrumental in producing in 1957, *The Plea for the Silent* (Johnson & Dodds, 1957), an exposé of abuses within mental hospitals. The Report of the 1954-7 Royal Commission on the Law Relating to Mental Illness & Mental Deficiency (the Percy Commission) was to prove the key document in the transition to a community-based system of treatment and care. Given the brief of investigating the law respecting certification and reviewing the administrative machinery governing extramural services, the Commission's recommendations promoted innovative concepts of the management of mental disorder. It recommended that

the law should be altered so that whenever possible suitable care may be provided for mentally disordered patients with no more restriction of liberty or legal formality than is applied to people who need care because of other types of illness, disability or social difficulty.

Compulsory powers could not be altogether abandoned, but they should be used, the Report recommended, 'only when they are positively necessary to override the patient's own unwillingness or the unwillingness of his relatives, for the patient's own welfare or for the protection of others'.

Though the Commission advocated community care, its bold stand (beyond its terms of reference) was hardly matched by the provisions of the Mental Health Act of 1959. Progressive hospital consultants nevertheless went ahead by speeding up patients' discharge: the total number of residents of psychiatric beds steadily declined from their 1954 peak of some 148,000 in England & Wales. Building on optimism about community care, policies were formulated of running down the old mental hospitals and then closing them down altogether. All that would continue to be required would be beds for the acutely mentally sick requiring short-term hospitalisation: these (it was envisaged) could be attached to general hospitals.

The 1960s saw these developments gather pace, as 'anti-psychiatrists' mounted their root-and branch critique of the old regime of the old mental hospitals. Led by Ronald Laing, a psychiatrist at Gartnavel Hospital, Glasgow, and by the South African, David Cooper, the anti-psychiatry movement should be seen against the backdrop of rising 1950s and 60s protest against traditional authority and bureaucratic torpor, whether it was expressed by the Teddy boy of the early 1950s, by plays such as John Osborne's *Look Back in Anger* (1956), or slightly later, by the CND movement and the Hippie and student protesters of the 1960s.

Cooper and Laing were angry young men themselves. They argued that schizophrenia (and, by extension, all mental illness) was not a disease but a stigmatising label, imposed by society and policed by psychiatrists. 'Schizophrenia', they suggested, might be best understood as rational behaviour in a mad world, perhaps a self-protective reaction against disturbed families and their 'double

binds'. Or it might even be a form of discovery and self-recovery. They insisted that psychiatrists and mental hospitals created crazy behaviour and degraded people, and committed themselves to putting their anti-psychiatric principles into practice through the development of 'anti-hospitals' (Tantam, 1991).

In 1962, Cooper organised a (short-lived) therapeutic community (Villa 21) for young schizophrenics at Shenley Hospital, north of London. They were also founder-members of the Philadelphia Association which opened a hostel, Kingsley Hall, designed to function as a community on anti-psychiatric lines. An attractive writer, inspired by existential philosophy, Laing in particular won a following amongst liberal intelligentsia at the time of the counter-culture and student protests against the Vietnam War. Films like *Family Life* (1971) and *One Flew Over the Cuckoo's Nest* (1975) mobilised public feeling against the 'policing' role of psychiatry and the archaic asylums.

At the same time, and from a different angle, politicians took up the cause of community care, advancing plans for reducing psychiatric beds and even phasing out mental hospitals altogether. Enoch Powell, Minister of Health in the Macmillan government, announced in 1961 that the old mental hospitals - 'isolated, majestic, imperious, brooded over by the gigantic watertower and chimney combined, rising unmistakable and daunting out of the countryside' - should be scaled down or closed down, and that those patients requiring in-patient treatment should instead be handled by local hospitals. In 16 years, Powell predicted, only half as many mental hospitals beds might be needed. Sir Keith Joseph, Minister of Health in the 1970 Heath administration, reaffirmed the new policy of running down the old mental hospitals.

Planning followed for both revamped hospitals and community care with, for the first time, the treatment and care of psychiatric patients being handled in the context of general health and social services. But the requisite resources were patchily and tardily provided. In 1951, only 8 full-time psychiatric social workers had been employed by local authorities in England; their numbers had increased to a derisory 24 by 1959. Some temporary improvement followed, but by the early 1970s, with rampant inflation and balance-of-payment crises, financial pressures exerted by the Treasury upon local authorities put the adequate realisation of community care into jeopardy. By consequence, the 1975 White Paper, *Better Services for the Mentally Ill*, pessimistically announced that, because of 'financial stringency, it is clear that the scope for making progress during the next few years will be very limited'. Anxiety about the shortage of money earmarked for mental services was also voiced in the Department of Health and Social Security's consultative document, *Priorities for Health & Social Services in England* (1976):

The most serious deficiencies in existing services for the mentally ill are in the local authority social services, where in 1974 there were fewer than 4,000 residential places, and only just over 5,000 places, against an estimated national requirement of 12,000 and 30,000 respectively.

Massive capital expenditure was needed, the report insisted, if adequate community services were to be provided:

Even with the prospect of a sharp reduction overall in local authority capital schemes, it is essential that capital expenditure for mental illness should be increased, not only as a proportion of the total but in absolute

terms, if there is to be any real progress either in meeting existing urgent needs or in developing the new pattern of services.

Financial restrictions were to tarnish the bright, idealistic vision of community care advanced in the bright new dawn of the Percy Commission. From the mid-1970s, public expenditure cuts and the negative attitudes to the poor and to the welfare state adopted successively by Mrs Thatcher's and John Major's administrations have meant that 'community care', once the great hope of humane psychiatry, first became a political football and then an object of rampant public suspicion. This 'failure' has contributed to the growing disillusionment, not least among the media and other vocal groups, with most forms of public and institutional psychiatry at the close of the twentieth century, bringing the wheel back full circle towards the chilly situation as of 1900.

During the last 20 years, growing cynicism, patients' rights lobbies, the exposure of administrative abuses and similar scandals, feminism, and other critical currents have questioned dramatically the standing of both orthodox professional psychiatric services and Freudian psychoanalysis alike. The psychiatric profession has become a sitting target for the press and politicians, not least when mental patients released into community care commit violent crimes or can be simply stigmatised by the Prime Minister as 'eyesores'. Child psychiatrists and psychiatric social workers are widely and, on occasions, almost ritualistically blamed by the media and by members of the Government for rising teenage promiscuity, juvenile crime, single-parent families, the soaring divorce rate, and other forms of social breakdown. A groundswell of public opinion, fanned by the popular press, now believes that psycho-sexual disorders are often the product of those very psychotherapeutic professions who purport to protect and help clients.

Thus deep irony attends the development of psychiatry within twentieth-century British society. The public became more receptive towards the fields of psychiatry and psychology; new modes of psychiatry became implanted, and old-fashioned institutions were reformed to meet criticism. Yet the longer-term consequence has not been growing acclaim, but a resurgence of suspicion. The twenty-first century will be faced – not just in Britain but across the Western world – with a glaring paradox: the simultaneous existence of a wider range than ever of public and private psychiatric services, with a profound crisis of public confidence in most aspects of the psy-professions.

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20 A History of the Richmond Asylum (St Brendan's Hospital), Dublin

BRIAN O'SHEA and JANE FALVEY

Because of its pivotal position in the affairs of both government and the mentally ill, the history of St. Brendan's Hospital, named after St. Brendan the Navigator (484-557), deserves more than the 'blank page' predicted by the Visiting Committee of 1933 (Reynolds, 1992).

The early days

Before asylums, lunatics in Ireland were made sport of, confined in holes in the ground, or incarcerated in gaols or poor houses. They were sometimes a public nuisance, as when they engaged in stone throwing, and a sizeable sub-culture of beggars, vagrants, and 'wandering lunatics' existed. Before Peel's Poor Law Act of 1838, the Dublin House of Industry, one of series throughout Ireland, was a mix of workhouse, penitentiary, and hospital. It had been opened in 1773 for the relief of the poor of the city, Under an Act of 1787 (27 Geo. III [Ire.], c.39, s.8), the House provided separate wards for pauper lunatics and idiots who had been certified by two magistrates.

The neighbouring Richmond Penitentiary was opened for the reception of prisoners in 1812, but 26 years later, the hospital part was separated from the workhouse and the penitentiary function disappeared. Although 10 cells for lunatics had been constructed in 1773, a separate house, the future Carmichael School, was built only 2 years later for 109 cases. In 1857, this department was closed and most of its charges sent to Lucan (West Dublin) under the care of a former governor, Dr. Stewart (Fleetwood, 1883); this formed the basis of the modern Stewart's Hospital for the Mentally Handicapped.

St. Patrick's Hospital had been opened in 1757, with the assistance of a bequest from Dean Jonathan Swift (1667-1745). This poet, author, and philosopher left the sum of £12,000 'to build a house for fools and mad'. It was to take both fee-paying and pauper patients, and receive its funds from voluntary donations and parliamentary grants (Malcolm, 1989). Completely private institutions were then rare in Ireland; the first private madhouse was founded in Downpatrick in 1782, followed by other private institutions in Cork, Dublin, and Carlow (Prior, 1993).

In 1805 a Bill was introduced by Sir John Newport, a Whig and prominent

Waterford banker, to establish four provincial asylums, each of 250 beds. It had been seconded by Colonel Bagwell, who referred to the disruption caused by clamorous lunatics in Clonmel gaol, impeding the recovery of the physically ill. However, because opponents believed that the laws were already sufficient, and because of the extra taxes which would have to be raised, the Bill was later withdrawn. Five years later, the governors of the Dublin House of Industry, together with Alexander Jackson (a physician interested in the management of the poor and in the care of 'lunatics'), secured a government grant of £12,000 to establish a separate asylum for lunatics. It was to take patients from the whole of Ireland and would be called the Richmond Lunatic Asylum after the Lord-Lieutenant, Charles Lennox, Fourth Duke of Richmond (Select Committee, 1843). However, 'the hardship and abuses that would inevitably be associated with a single centre when the great bulk of the population was scattered, rural in character, and far removed from Dublin' (Robins, 1986, p. 62) was ignored in this proposal.

For most of its history, the Richmond Asylum was to be the largest facility for lunacy in Ireland. Its building, which became known in the twentieth century as the 'Lower House', was square-shaped, had three stories, and sported the Richmond coat of arms. Francis Johnson was the architect, using the plans for Bethlem Hospital, and, for £141, Richard Stewart designed the coat of arms.

Moral Governors

Under an Act of 1815, Governors were appointed to the Richmond Asylum who would be independent of the House of Industry, where a large number of lunatics had previously resided. A Moral Governor was to be their executive arm: Richard Grace held that position from 1815 to 1830, followed briefly by Dr. William Heisse, while Samuel Wrigley was the third and last holder of the title (1831-1857). Initially, there were 15 Governors, 2 physicians (Alexander Jackson, Hugh Ferguson), and a surgeon (Andrew Johnson). The nomination of Asylum Governors by the central authorities lasted until the Local Government (Ireland) Act 1898, when all such institutions came under the control of local councils. The first hospital secretary was William Wainright, James Hendrick the first accountant, while Jane Fitzpatrick, the Housekeeper, was charged with changing the straw in the inmates' bedding every fortnight. The Porter's duties included the prevention of escapes – two meant his dismissal.

Early asylums, including the Richmond, were managed not by medical practitioners but by laymen. Though the total control of a Moral Governor over the management of inmates rested on a belief in the efficacy and humanity of 'moral treatment', this has been described as 'a pleasant illusion' (Robins, 1986). Whilst accepting that the concept was a positive advance over previous thinking, he believes that it was doomed to failure because of the overcrowded conditions (Robins, personal communication, 1992). Williamson (1970, 1992), on the other hand, has argued that moral management was reasonably successful in the first half of the nineteenth century.

Since the Moral Governor was responsible only to the Asylum Governors, resistance to such posts and support for medical leadership came from the few apothecaries or physicians (such as James Flynn, a physician in Clonmel)

appointed to the institutions, as well as from visiting physicians. By virtue of his professional standing, however, Dr. John Jacob, physician to Maryborough Asylum (Portlaoise) was seen as having greater authority than the lay manager (Williamson, 1970).

In 1818, Richard Grace, the first Moral Governor of the Richmond Asylum, warned the Board of Governors that unless something was done to reduce the numbers of inmates, the original curative functions of the asylum would be frustrated and that it would become a 'depot of incurables' (Reynolds, 1992, p. 34). On a more positive note, Grace was able to record that of 83 patients discharged during the previous year, some had gained useful employment outside the hospital, while five had continued to work as servants of the institution. In his report of 1826, Grace praised the industry of the female patients who produced considerable quantities of clothing and kept the clothes of all inmates in repair. He also recorded the 'appreciation of the arrangements and management of the asylum' expressed by 'several persons of distinction of this and the sister kingdom' (Reynolds, 1992, p. 43). In the following year, however, the Inspectors of Prisons, castigated the Richmond, which they considered not managed as efficiently as the neighbouring and larger Dublin House of Industry. Grace died in office in April 1830.

Grace was succeeded as Moral governor by Dr. William Heisse, a German who had served with the British army in the Peninsular War. Prior to his appointment to the Richmond, Heisse had been in practice in Borrisokane, County Tipperary. Overcrowding persisted, supervision appears to have been poor, and, on the advice of the Inspectors of Prisons, the Lord Lieutenant removed Heisse from his position in 1831. Nevertheless, the Board of Governors, partly in response to an appeal by Heisse, and largely because they were bypassed in the decision to sack a senior officer of their asylum, granted Dr. Heisse a testimonial in which they wrote that 'his moral and professional character stand unimpeached' (Reynolds, 1992, p.49).

Samuel Wrigley, a lay Moral Governor, and a former superintendent of the Dublin House of Industry, rarely visited the wards (Royal Commission, 1874). He 'had no professional qualifications of any sort nor any experience of dealing with the insane apart from a brief term of instruction in the Dublin House of Industry prior to taking up office' (Robins, 1986, p. 93). However, he did introduce (poorly) paid work for inmates, though it was not until 1961 that all mental hospital patients officially received payment for work done (O'Shea & Falvey, 1984; Reynolds, 1992, p. 81). Wrigley's wife took up her position as matron on the same day as her husband.

The Wrigleys seldom resorted to coercion, preferring 'mild and conciliatory treatment' (Reynolds, 1992, p. 51). Though not claiming that agricultural labour cured his charges, Wrigley believed that it helped them to sleep, 'that greatest of all blessings to the troubled mind' (Reynolds, 1992). The Governors were compelled to employ an additional keeper in 1833 because of the security problems created by the admission of patients from the jails of Dublin.

In 1857, a Commission of Inquiry under the chairmanship of Sir Thomas Reddington, a former Irish Under-Secretary, visited the Richmond. Dominic Corrigan, physician to the Dublin House of Industry Hospitals and later president of the King & Queen's (now the Royal) College of Physicians in Ireland, was the most distinguished medical member of Reddington's team. Wrigley did

TABLE 1

<i>Irish Asylums (and year of opening)</i>	
Richmond (1814)	Killarney (1852)
Armagh (1824)	Cork (1852)
Limerick (1827)	Mullingar (1855)
Derry (18827)	Sligo (1855)
Belfast (1829)	Castlebar (1866)
Carlow (1832)	Letterkenny (1866)
Maryborough (1833)	Ennis (1868)
Clonmel (1834)	Enniscorthy (1868)
Waterford (1835)	Monaghan (1869)
Kilkenny (1852)	Ardee (1933)

not acquit himself well, giving evasive and untruthful answers (Reynolds, 1992, p. 111). The Richmond Governors, evading responsibility for their less than enthusiastic interest in the asylum, dismissed the Wrigleys, but, perhaps by way of assuaging their collective conscience, awarded them both pensions – £207 and £86 respectively – under the terms of the 1856 Superannuation Act.

A District Asylum

The next hospital to be opened was that at Armagh in 1824; 17 more came into being up to 1869, and a further one at Ardee in 1933. The demand for admissions continued to be high, despite a declining national population (Robins, 1984) (Table 1).

The Richmond Asylum became a District Lunatic Asylum in 1830; the term roughly corresponded to the English County Asylum, although many Districts included more than one county. By 1884, Ireland had 45 asylums: 22 district, 22 private, and one criminal. In the previous year, there were 14,088 registered lunatics in the country, housed both in the various asylums and in the 163 poorhouses (Miles, 1988). Statutory sanction was given to change the name from 'lunatic asylum' to 'mental hospital' under the Local Government Act 1925 (s.79), while workhouses became styled as 'county homes' in 1925. In 1950, a proposal to change the name of Grangegorman (Richmond) to St. Dymphna's Mental Hospital was made at a meeting of the hospital's Board, but never went beyond the discussion stage. The subject was brought up again in April 1958, and on this occasion, the name St. Brendan's Hospital was adopted unanimously.

Resident Medical Superintendents (RMS)

The work and conditions

With the passage of time, medical managers adopted the title of 'resident physician' (RMS). Calls for doctors to be appointed as managers of asylums were published in the journals, both in signed (Winslow, 1848) and anonymous (Anon., 1846) forms, but opposition to such posts came from the famous physician Dominic Corrigan, who championed the cause of the Visiting Physician. The RMSs of the Richmond Asylum / St. Brendan's Hospital are listed in Table 2.

TABLE 2

The Medical Superintendents of St. Brendan's Hospital, Dublin

Dr. Joseph Lalor (1857-1886)
Dr. Conolly Norman (1886-1908)
Dr. John O'Connor Donelan (1908-1937)
Prof. John Dunne (1937-1966)
Prof. Ivor W. Browne (1966-present)

Though the Resident Physicians had to give up private practice, their salaries were poor. Writing to the Richmond Governors in 1896, Dr. Norman asked for an increase in salary, enclosing details of British remuneration for comparison, and stated that: 'No Irish Asylum in G.B. and in Ireland approaches closely to the Richmond in size, and probably none equals it in difficulty of management.' His salary was £800 *per annum* with allowances valued at £100.14.5. At that time, the Medical Superintendents of Hanwell and Colney Hatch Asylums each received £1,000, with allowances valued at £150. Absence from the main place of work had to be strictly accounted for, as minuted by the Board of Governors on 4.12.1894: 'With respect to Dr. Connolly (sic) Norman's absence from the Asylum, the Board take the responsibility for it. Dr. Norman was absent on vacation, and during a portion of it resided at Portrane and attended to certain matters at Portrane'.

Strictly speaking, the RMS received his appointment from the Lord-Lieutenant of Ireland, whereas an English superintendent was, until 1889, appointed by the Committee of his respective asylum, and was answerable to it, and was paid by it. Canvassing for the position was common. For an assistant medical officer (AMO) training was 'not always regarded as indispensable, and no applicant trusts to these qualifications without other support' (Burdett, 1891, p. 255). Though Irish RMSs were appointed by the State, they were paid by local ratepayers. In 1876, they sought to improve their status by seeking direct payment from the State, i.e. to become civil servants. This approach received support from the *Journal of Mental Science* (1877, p. 559):

Once secure of their position as Civil Servants, the rest would follow; their services would reckon, now matter how often changed from one asylum to another; they would no longer hold the anomalous position of men appointed by Government, responsible to central authority but paid by the ratepayers and as Civil servants they would come under the Superannuation Act of 1859. Above all, they would become more closely connected with the Government, and obtain greater support and assistance in their official duties and in their attempts to further the study of mental disease in Ireland.

However, local funding was to continue, under the county councils, which were established in 1898 in place of the Poor Law Guardians. Under the Health Service (Miscellaneous Provisions) Act of 1947, central funding at first matched and then took over from local funding. Finally, 1978 saw the abolition of local rates.

The Board of Governors met once a month in all asylums except the Richmond, where they convened on a fortnightly basis. They appointed all staff except the RMS. Whereas the appointment of 'officers' was subject to the approval of the Lord-Lieutenant, in practice, this was merely a matter of

form. The appointment of 'servants' (attendants, nurses, etc.) was legally a Board matter, but was often delegated to the RMS. The exclusion of the RMS from the board-room in the Richmond Asylum was seen by English commentators as a 'strange deviation', adopted for 'entirely inexplicable reasons'. This policy was blamed for a 'chronic state of indiscipline', in that the RMS could be overruled by the Board when he disciplined staff (Burdett, 1891, p. 252). The majority of Irish RMSs had less power but greater responsibilities than had their English counterparts. They had no legal say in the appointment of subordinates; could not dismiss one, and whilst they could suspend a servant, they might be humiliated at the next meeting of the Governors, should the latter reinstate an offender. The exercise of discipline over staff who were violent towards a patient could lead to retributive insubordination (as when some 'keepers' refused to take orders, although usually feigning compliance), as Conolly Norman discovered in the 1890s (Finnane, 1981, p. 210-211). This did not deter him, though, from reporting breaches of discipline: 'I am sorry to have to report a grave irregularity. This day fortnight, after the meeting of the Board, Nurse . . . [female] was found to be under the influence of drink while on duty. This woman's record is not favourable, and I must reluctantly say that I think she is unfit to be in charge of the insane and ought to be dismissed' (Letter to Board of Governors, Tues., 8.32.1898).

According to the *Journal of Mental Science* (1877):

. . . Irish Superintendents were required to perform so many and so various duties that little time was left to them for the cultivation of the scientific branches of psychology, that they are, for instance, held responsible for the discharge of duties that in England fall to the share of the Clerk to the Committee of Visitors, and to the Steward of the Asylum.

Furthermore, all these duties (reports, farming, paying salaries and wages, etc.) 'had to be performed without even the assistance of a second resident medical officer' (p. 164).

The sundry responsibilities of the Irish RMS are well illustrated by the various reports of John Dunne to the Grangegorman authorities. In April 1938: 'The drainage from No. 24 division . . . discharges into a built sewer underneath the railway at the Broadstone [behind the North Dublin Union or poorhouse, for a time occupied by the British army], and this sewer runs a considerable distance before discharging into the Corporation's main drainage system. Last week this built sewer got choked and it was found impossible to clear it'. A month later, he was dealing with the application from the National Union of Tailors & Garments Workers for a five-day week. Despite these concerns, Dunne still found time to record the various 'amusements' enjoyed by his patients.: 'The Father Mathew Players were brought in by Mr. Farrell, Foreman Tailor, on Sunday, 20th [March], to entertain the patients. A very excellent concert was thoroughly enjoyed by all the patients and staff' (Report of Chief RMS, 1938).

Whilst the National Union of Asylum Attendants in Ireland was formed in 1896, the Irish Division of the Medico-Psychological Association (MPA) felt sufficiently confident in its own status to attempt to suppress such organisations (Walk, 1961; Nolan, 1991). This was presumably because of contemporary

attitudes toward organised labour, and also perhaps because of the perceived threat to its authority. Undoubtedly, directions from the Boards of Governors to the RMS to suppress union membership were crucial in individual circumstances. Conolly Norman in fact dismissed two attendants who refused to resign from the Union.

There was a lively discussion about pensions at the Quarterly Meeting of the MPA of December 1887, which took place at the Richmond Asylum. A Bill had been introduced into Parliament to amend the Superannuation Act then in force in Ireland: it stated that pensions should only be granted at the will of Boards of Asylum Governors 'and not otherwise'. Dr. Norman felt that the Bill excluded medical superintendents from any chance of a pension. Though it offered two-thirds of the RMS's pay after only 15 years service, Conolly Norman saw it as a trap (*Journal of Mental Science*, 1888), since it left too much to the whims of the Boards. However, the Bill failed in the House of Lords, having had no seconder.

Teaching

The Irish RMS was not highly regarded by English psychiatrists who had an academic interest (Burdett, 1891, p. 261): 'To the mass of literature dealing with insanity in every aspect which has enriched the English physician's library during the last forty years, Ireland has contributed, it may be said, nothing'. However, the same source (p. 244) was not entirely negative: 'It must be said that the majority of Irish superintendents have manfully striven to improve the material condition of their unfortunate charges, and under circumstances of great difficulty'.

Nevertheless, the teaching of psychiatry at St. Brendan's Hospital has a long tradition:

Instruction in mental diseases seems to have been in contemplation from an early period in this century. It was, however, due to the enlightened and disinterested action of a distinguished Dublin physician, Sir John Banks, K.C.B., consulting and visiting physician to the Richmond Asylum, Dublin, that it was ever introduced . . . when the Royal University of Ireland was being founded, that gentleman, who took an influential part in the proceedings, succeeded in persuading the University to include a course of clinical instruction in mental diseases in its curriculum. Since then the Royal University has received certificates from the medical superintendents of the Richmond Asylum, Dublin, and the district asylums of Cork and Belfast. (Burdett, 1891, p. 262)

Introducing such instruction, though, was not always easy in Ireland. In response to the proposition that medical students should receive teaching in lunacy at the Cork District Lunatic Asylum, one of the Governors wrote in 1877: 'Is it for the lunatics he [Dr. A. Eames, RMS] requires the lectures? Was any such humbug heard of! And do you really think that a medical man is necessary to tell you whether a person is insane or not' (Henry, 1989, p. 148).

The Medical Superintendents

Joseph Lalor M D

Dr. Lalor, who has been described as 'excellent and kind-hearted' (*Journal of Mental Science*, 1886), had been Resident Physician to the Kilkenny Asylum (now St. Canice's Hospital) from its opening; prior to this, he had served as senior medical officer of the Kilkenny workhouse and as physician to the lunatics of the local gaol and cholera hospital. Lalor was a graduate of the College of Surgeons and received an MD at Glasgow in 1839; he was appointed to the Richmond Asylum in 1857. He was appalled at what he saw there: confinement of inmates in cells, lack of open-air exercise, nocturnal exercise only, and patients who were fed only when it suited the attendants. Lalor put a stop to all of this. In the closing years of Wrigley's administration, the senior officers of the Richmond had become accustomed to adopting procedures on their own initiative. The chief offender was the apothecary, Pakenham Beatty, who regarded himself as outside Lalor's authority. In October 1858, Lalor complained about Beatty and the clerk/storekeeper to the Governors of the Richmond (Reynolds, 1992), but the resolution of these problems became caught up in the argument over the status of Visiting Physicians, a subject peripheral to this chapter.

According to the *Journal of Mental Science* (1886), Dr. Lalor 'enthusiastically carried out the school system'. In fact, the female side had had a school for two years prior to his arrival, but he introduced one for the men and procured extra teachers. According to Burdett (1891, p. 260), the only asylum to have a school at this early date was the Richmond. 'Singing and music were much cultivated, while object and picture lessons were given, as well as others in natural history and geography'. Some of these paintings were exhibited to the public and 'attracted considerable attention'. Regular concerts, greatly improved furniture in rooms and corridors, and the bringing together of patients to dine brightened their lives.

Lalor was elected President of the MPA for 1861, when he argued for the support of the lunatic poor from state funds, stating that many inmates were incarcerated for the protection of society, not 'for their own advantage' (*Journal of Mental Science*, 1861). He was not allowed to attend Board meetings and his authority was diminished by the presence at them of one of the Inspectors of Lunacy (Burdett, 1891, p.252): 'Indeed, to judge from the complaints of the late distinguished superintendent, the place in the board-room, from which he was excluded, appears to have been taken by one of the late inspectors, who acted as assessor to the board of governors. Why this strange deviation from the entire spirit, and seemingly from the distinct letter, of the Privy Council Code was adopted or permitted is entirely inexplicable.'

The MPA visited the Asylum on Saturday August 17, 1861. According to the *Journal of Mental Science* (1861a):

[We] visited the wards and spacious grounds . . . much satisfaction was expressed. The inmates . . . were employed in a variety of useful and healthful occupations, both in-door and out-of-door. The females, in particular, were well furnished with suitable employment, and were very comfortably and respectably clad. School instruction is carried out amongst them to a large extent, and the progress made in singing in the department has been very considerable and

successful; fair proficiency is also made in band music by the men.
(p.388)

Two days earlier, the Annual Meeting of the Association was held at Reynold's Hotel. After Dr. Bucknill's Valedictory address as ex-president, Lalor spoke of insanity as being open to social influences (*Journal of Mental Science*, 1861b). He included the importance of studying psychosomatics (defined as body-mind interactions in health and disease), the relevance of the social sciences, the deaths in the asylums from the famine fever of 1846-47, the necessity of acting normally with the insane, the great need for training in psychology in medicine, the need to appoint educated senior attendants, the non-infectivity of insanity for staff, moral treatment, and the sore subject of the status of resident versus visiting physicians. Madness, he said, is 'most effectually undermined by the withdrawal of the mind from their contemplation, and by the cultivation of opposite and healthy trains of thought by industrial and literary teaching, particularly in class and in public lectures, and by games and amusement' (p. 324).

Dr. Lalor retired to Sligo and died at the age of 75 after a short illness on August 17, 1886, only a few weeks later. Daniel Hack Tuke described him as a 'credit to Ireland', and praised his system of employing and training the patients, which was the best he had seen (Robins, 1986, p. 139). The *Journal of Mental Science* referred to Lalor as 'an originator and an enthusiast, an accomplished physician and an able administrator, a genial, high-spirited gentleman, whose qualities of heart and brain gained the confidence and secured the affection of all with whom he was brought in official relation . . .' (p. 344-5).

Conolly Norman FRCPI, FRCSI

The second RMS of the Richmond Asylum was born in All Saint's Glebe, Newtown-Cunningham, County Donegal, in March 1853, the fifth of six sons of the local Protestant rector. He studied medicine at Trinity College, Dublin, the Carmichael School of Medicine, and the House of Industry Hospitals. He received the licences of the King & Queen's College of Physicians in Ireland and the Royal College of Surgeons in Ireland in 1874, becoming FRCSI in 1878 and FRCPI two years later. He became Assistant at Monaghan Asylum (now St. Davnet's Hospital) and, after five years there, went to work under Dr. George Savage at the Bethlem Hospital, London, for two years. In turn, he was Superintendent at Castlebar (1882-5) and Monaghan (1885-6) asylums, before taking up the same position at the Richmond in 1886 – a post he held until his death in February 1908.

In 1894, he was President of the MPA. A regular attender at meetings, he had been a member since 1880, and Irish Secretary from 1887. For many years, Dr. Norman was Editor of the *Journal of Mental Science* (now the *British Journal of Psychiatry*). He wrote widely, particularly case reports and essays on family care systems (e.g. Norman, 1896); influenced by developments in Germany, Norman saw the domestic treatment of the insane as a superior model to asylum treatment. His wish was to admit patients voluntarily, and so far as possible without any legal formalities. He continued Lalor's educational approach, considering that literary and musical practices, 'though inferior to industrial

labour', had good disciplinary, calming, and idleness-preventing effects (Burdett, 1891, p.260).

However, since the Richmond Asylum generally contained some 1,500 patients during the 1890s, Norman found it hard to apply individual treatment: 'The huddling together of vast crowds of people . . . (impedes their recovery) . . . and the vicious circle goes on without end' (Norman, 1905). He could see insufficient evidence for the strong position enjoyed by hereditary theory in contemporary psychiatric thinking (Robins, 1986, p. 113), and denounced eugenics (Norman, 1904). Unusually for his time, Conolly Norman often saw outpatients and their relatives at his office (Robins, 1986).

In January 1898, the population of the Richmond Asylum was 1,888, of whom 1,101 were from Dublin City, 425 from the County of Dublin, 154 from Co. Louth, and a further 14 from Drogheda. These areas had comprised the catchment area of the Asylum ever since 1830. Such large numbers prompted Norman to write to the Governors: 'May I once more bring under the notice of the Board the desirability of appointing a Visiting Committee, so that the wards should be visited regularly, and that the Governors might learn for themselves the requirements of the Institution' (C. Norman. Letter, 11.1.1898).

The diverse responsibilities of the RMS are illustrated in another letter to the Governors on July 1, 1896: 'There are about sixteen sheep at Portrane which are fit to sell. Some of the larger bullocks will soon be fit for sale. Will the Board kindly instruct me what is to be done with them'.

Conolly Norman's obituarist described him as a very popular man (*Journal of Mental Science*, 1908). ' . . . in a comparatively short time he raised the institution to the very first rank, not in Ireland merely, but in the world' (p.204). He was a linguist, fond of foreign travel (presumably with the Governors' permission), an attender of foreign professional meetings, and a possessor of a wide knowledge of the literature. Norman had a fine taste in art, was a competent archaeologist, and had a good knowledge of architecture and music. Whilst he wrote on clinical observations and had contributed numerous clinical reviews, 'it was as a letter writer that he was most delightful' (p.206). A few years after arriving at the Richmond Asylum, Norman had received the blame for an outbreak of beriberi. The strain is said to have 'weakened his heart' to such an extent that Sir Douglas Powell advised him to go to San Remo. Following Parliamentary questions, the Lord-Lieutenant investigated the matter and shifted the blame on to Norman's detractors. His health improved, but the incident was said to have left him with a cardiac disability 'which has now brought him to the grave' (p.204).

Examples of papers published by Norman are: '*Two cases of larvated insanity*' (1886), concerning patients whose mental illness remained unnoticed for years despite being subjected to 'peculiar scrutiny' in their jobs; and '*Cases illustrating the sedative effects of aceto-phenone (hypnone)*' (1887). He had found this substance useful in 'recurrent excitement associated with sleeplessness', and advised that it be given with a hypodermic syringe.

Believing that asylums were not conducive to recovery, and that they entailed an intolerable life for many inmates, he suggested that many patients would be better off being boarded out with suitable families – a fashion that never achieved success in Ireland, however. Inspectors wanted more and bigger asylums, since boarding out in workhouses proved to be only slightly less daunting for 'harmless lunatics and idiots' than being sent to gaol (Burdett, 1891, p.251).

Dr. Norman died on a Sunday afternoon whilst walking out from his home 'St. Dymrna's', built in 1895 and later to become an alcoholism treatment centre until 1992.

John O'Connor Donelan LRCPI

O'Connor Donelan was born in Tuam, Co. Galway and died approximately 91 years later in 1978. He qualified from the Royal College of Surgeons in Ireland. After working at St. Vincent's Hospital, St. Stephen's Green, and the Richmond Asylum (Assistant Medical Officer, 1898), he was RMS of the Richmond Asylum from 1908 to 1937. According to his son, Dermot (Personal communication, 1992): 'he was much older than his wife, Rita Moore of Ashtown, when they married in 1910. I was born two years later, the only one to do Medicine [dermatology], and was followed by 2 boys and a girl. My father was very quiet, kindly, and did not advertise himself. His interest was mechanical engineering. We had a big garage at St Dymrna's. He got his first car in 1899, and, unusual for the time, he had two electric lathes and a plentiful supply of tools'.

In the early twentieth century, the Richmond was enclosed by high walls. In October 1908, 300 lunatics were received from the local workhouse as part of the reorganisation of the latter establishment, a further 100 going to Portrane Asylum. The recovery rate, which averaged at 28% of admissions, peaked at 36.5% in 1912 (O'Shea & Falvey, 1984). Well over 300 British soldiers were treated in a special unit in the Asylum grounds during 1916-19. The 1916 Rising in Dublin had caused some disruption of supplies for the hospital, but only one staff member joined the insurgents. An outbreak of dysentery in 1917 was blamed by Donelan on the lack of coal, related no doubt to the requirements of the British Navy. Female doctors and unfit males were recruited to fill the gap in personnel created by the War. In 1919, working hours for attendants or 'keepers' were reduced from 80 to 56 per week. Dr. Donelan appealed to the Board in the same year for reading material for inmates (O'Shea & Falvey, 1984).

Because he considered the environment to be unsuitable, Donelan expressed disdain towards the referral of mentally handicapped children for admission, but favoured the compulsory admission of alcoholics and drug misusers. He considered the expansion of asylum farms to be important in the treatment of patients. He also wished to integrate the male and female nursing staff, St. Brendan's being then divided into Male and Female 'Sides', as was usual in asylums of the time. However, integration of staff and patients was to be delayed until the 1980s. The Asylum acquired the North Dublin Union (poor-house) in 1920, while responsibility for Co. Louth was handed over to Ardee Asylum (now St. Brigid's Hospital) after 1930. Despite the opposition of local businesses, Donelan made a success of alcohol-free canteens in Grangegorman (as the Richmond Asylum began to be known) and at Portrane. (From this point, the title of 'Chief RMS' appears, referring to responsibility for both asylums.)

In 1934, Donelan went on a tour of Britain and the Low Countries. He was impressed by what he saw (Gheel, radio-therapy, twilight sleep, hydrotherapy, and occupational therapy) and reported on his travels to the authorities (O'Shea & Falvey, 1984). He was concerned that psychiatrists in Ireland tended to see patients only at an advanced stage of illness.

Much of the increase in population in post-famine Ireland had been due to a rise in the number of people living beyond the age of 65. As a result, there was a parallel increase in the demand on asylums to take on the care of the feeble elderly, and Donelan complained that the North Dublin Workhouse was committing too many of these to his care (Finnane, 1981, p.1443). Dr. Dermot Walsh, Inspector of Mental Hospitals for Ireland at the time of writing, has argued in a paper ('The ups and downs of schizophrenia in Ireland') read in Dublin to the Royal College of Psychiatrists 1992 Annual Meeting that the increase in asylum numbers in both the nineteenth and twentieth centuries was not due to an increase in the incidence of schizophrenia, but rather a result of industrialisation, urbanisation, improved agricultural science, and the 'humanitarian climate of [the] 19th century'. In a report of April 1909, Donelan had found that:

the increase in stimulants . . . is due to the large number of old and feeble patients admitted recently from the workhouses. There has been an increase in the use of brandy, and a decrease in the use of whiskey. The former stimulant is entirely used in the infirmaries for exceptionally critical cases . . . every effort is being made to keep the issue of stimulants at the lowest possible point consistent with the proper treatment of our patients.

Donelan viewed paranoia as an inborn defect with a poor prognosis, and was worried because so many of these patients were able to effect their discharge through their skill in concealing delusions: 'In one remarkable case, where no symptoms could be discovered for six months, the patient wrote a long letter, full of the most exalted and paranoid delusions, to the head attendant the day following his discharge' (*Journal of Mental Science*, 1927, p.179).

An interesting case of his concerned a depressed patient with hypertension: trinitrin reduced the blood pressure, but failed to maintain it at a normal level. 'Unfortunately, a cerebral haemorrhage ended the experiment' (*Journal of Mental Science*, 1928, p. 576).

Donelan's successor, John Dunne (Personal communication, 1984), described him as 'very precise, a very fine chief, not very academically minded, concentrating on the patients' comforts, and interested in providing occupational and recreational activities'. Donelan was also a supporter of an ill-fated recommendation that a central laboratory be established for Ireland where pathological research into mental disease could be undertaken (*Journal of Mental Science*, 1933, p.832).

In 1936, compulsory retirement was introduced for public servants aged 65 years or over. Before leaving, Donelan submitted a report to the Joint Committee of Grangegorman and Portrane Hospitals in which he suggested that each branch hospital should have its own RMS, the post of deputy RMS (at Portrane) be abolished, and that the RMS of Grangegorman become Chief RMS (Reynolds, 1992, p. 262). This advice was adopted, and after carrying on at the request of the Committee until Dunne could take over, Donelan took his leave in August 1937.

Professor John Dunne, MD, BCh, DPM, DPH

John Dunne was born in Co. Offaly on January 5, 1899. He graduated from University College, Dublin (UCD), in 1922 and passed the DPM in 1926. After working in St. Brendan's (for £200 p.a.) from 1922-9, he completed his training in Vienna with Wagner von Jauregg, who received the Nobel Prize in 1927 for the malarial treatment of GPI. Dunne attended Freud's lectures there, but found them difficult to understand.

About Vienna, John Dunne wrote: 'The Psychiatric Clinic . . . forms part of the large general hospital of Vienna. Wagner Jauregg is still the guiding spirit, and unites under his able leadership the various schools of treatment . . . It is the Mecca of students from all parts of the world, and there is an ever-growing population of foreigners who are willing to pay for the privilege of working in the Vienna Clinic' (Dunne, 1930, p.181). He then worked for a period in Sligo, before replacing Donelan at St. Brendan's in 1937, also becoming RMS of Portrane Asylum. St. Ita's Hospital, Portrane had an internationally famous farm, run by long-stay inmates (O'Shea & Falvey, 1984), which produced the larger part of the diet of both hospitals. St. Brendan's was largely self-sufficient with workshops, an operating theatre, and recreational facilities (cricket, tennis, football, dances, concerts, outings). Dunne was a strong believer in what he termed the 'internal community', i.e. an asylum which contained most of the elements of normal living, but was demarcated from the outside world. Visiting physicians and surgeons supplied a comprehensive medical service to the in-patients.

ECT was given for the first time at St. Brendan's in 1938, and insulin coma therapy was introduced soon after it was described in the literature. In the 1930s, phenobarbitone and morphine were the most commonly used drugs in the hospital. Dunne would allow no patient to be consigned to a padded room without his permission; he foresaw the modern concept of seasonal affective disorder by using ultraviolet light for depression. He was a strong advocate of apomorphine aversive therapy for alcoholism, and because of its alleged calming effect in horses, he used Vitamin E for adolescent adjustment problems! An EEG Department was set up within the hospital, but this no longer exists, although such services are widely available in Dublin. Dunne found leucotomy especially useful for recalcitrant phobias, including agoraphobia.

Whilst an AMO at Grangegorman, Dunne described the malarial treatment of general paralysis of the insane (Dunne, 1926). Of 25 cases, mostly in an advanced state of dementia, 8 were greatly improved, 7 slightly improved, 5 showed no improvement, and 5 had died – one death from pneumonia, 2 from fits, and 2 'as a direct result of their demented condition'. The greatest improvement was said to have occurred 'in those cases where the temperature was very high, and where the course of malaria extended for more than ten rigors'. Despite initial doubts, the RMS, Dr. Donelan, became 'convinced of the great value of this treatment' though how it effected the good results 'was still a mystery' (*Journal of Mental Science*, 1926a, p.442). This was a considerable change of attitude for someone who had experience of 35% 'apparent remissions' [not explained by Donelan] of GPI in 1925 without any special treatment; great care, he declared, should be taken before attributing

curative qualities to any procedure in GPI (*Journal of Mental Science*, 1926b, p.626).

Dunne travelled widely and, surprisingly, was particularly impressed by Russian psychiatry. In Moscow, he found high staff:patient ratios, small units, and 'democratic' relations between doctors and clients! He opened the first psychiatric outpatient clinic in Ireland, at Mercer's Hospital, Dublin, where he was Psychiatrist from 1949 to 1983 (Lyons, 1991). In later years, he was also on the staff of Sir Patrick Dunn's Hospital. He believed that psychotropic drugs were over-used, because of pressure on psychiatrists to discharge patients quickly (Dunne, 1991). In 1950, he became Ireland's first professor of psychiatry (at UCD), and was President of the RMPA for 1955-6. He delivered his Presidential Address in Dublin, discussing the various contributions to understanding mental function, such as electrophysiology, cybernetics, and psychoanalysis; each was a different but related approach to the same goal, and religious beliefs were not refuted by their findings (Dunne, 1956). He continued to undertake clinics at Our Lady's Hospital, Drogheda, until June, 1990, but died on January 1, 1991. In his later years, he lamented increased permissiveness and the passing of stable role models in society (personal communication, 1984). His son, David, is a psychiatrist in Cork.

Professor Ivor Browne MSc, FRCPI, FRC Psych.

After qualifying, Ivor Browne worked with Joshua Bierer in London and with Eric Lindeman and Gerald Caplan in Boston. He returned to Ireland in 1962. After working at various Dublin hospitals, he came back to St. Brendan's as RMS in 1966.

His immediate aim was to transform the hospital, despite powerful resistance from 'the Institution itself' (personal communication, 1984), by dividing its staff into three community-based psychiatric teams. Each of the three teams developed their own catchment areas, based on smaller outlying hospitals (St. Vincent's Hospital, Fairview; Vergemount, Clonskeagh; James Connolly Hospital, Blanchardstown), while two private hospitals (St. John of God and St. Patrick's) also provided beds for public patients. Within the hospital, units were established on the basis of diagnostic groupings, an Assessment Unit was started, and outings and holidays were encouraged for the patients. He hoped that the poor state of many of the buildings would force an improvement in conditions, but was troubled by governmental failure to live up to promises of funding, and by the 'collusion of society to put problems out of sight'. He hoped to turn the St. Brendan's complex into a 'resource centre' for social skills training and a creative leisure area for the 'socially deprived', including those without psychiatric disorder. More recently, a 'church project' involved the use of a converted church for abreaction therapies, using a variety of techniques (chemicals, music, hyperventilation) to integrate what he calls 'unexperienced experiences', i.e. early traumatic memories which have not been fully accepted by the psyche (McGee *et al*, 1984). By inclination, Browne is a systems theorist, emphasising the effects of change and of stabilising mechanisms on functional components of the individual soma and psyche, as well as on the socio-cultural environments. He had the high walls around the hospital torn down, though,

because the homeless, intoxicated, or criminally-inclined often sought shelter or booty on the grounds, these had to be replaced by equally high railings.

Junior medical staff

The Assistants to the RMS in Ireland corresponded to Assistant Medical Officers (AMO) in English and Scottish asylums. However, in 1890, out of 22 district asylums, only 10 were provided with AMOs; two of these, Dublin and Cork, had two each. Canvassing for these jobs was 'expected' (Burdett, 1891, p. 258). Matters had improved somewhat by 1938, although it was still difficult to get a day off:

I have received an application from the Assistant medical officers to be allowed a whole day free in rotation. At present the medical officers have no whole day free apart from their annual leave. As there are five medical officers now in Grangegorman [Richmond], I think their application could be granted without unduly upsetting the work, and I recommend accordingly. (Approved). John Dunne. (Report of Chief RMS, 6.1.1938)

Conolly Norman (1896) warned of the dangers of institutionalisation among doctors because of the dreary, unchanging atmosphere of work in asylums, and suggested that they should detach themselves from it mentally by maintaining a 'broad-minded view of life'.

Finnane (1981) states that, due to overcrowding, it became impossible for doctors to tell one chronic inmate from another, this extending even to mistaken identity among the dead (p.186)! Every member of the staff was over-extended, even the hospital secretary having to double as a storekeeper (Burdett, 1891, p.259).

The Richmond and the Irish Branch of MPA

In 1871, there were 27 members of the MPA in Ireland, compared with 40 in Scotland (*Journal of Mental Science*, 1871-2, p.440). In the same year, Henry Maudsley, its President, stated that there had been few articles contributed from Irish sources to the journal of late, but he hoped that this would improve (*Journal of Mental Science*, 1871-2, p. 440). The Irish Branch or Division was formed at a meeting held in the King & Queen's College of Physicians, Kildare Street, Dublin, on the 16th October, 1872. Dr. Duncan, of Finglas in North Dublin, presided. Also present were Dr. Lalor (RMS, Richmond), Dr. Leney (assistant to Lalor), Dr. MacCabe (Resident Physician, Dundrum), Dr. John Eustace (Dublin), Dr. H.H. Stewart (Dublin), Dr. Robert Stewart (Belfast), and Dr. Patton (Farnham House, Finglas) (*Journal of Mental Science*, 1873).

The Richmond/St. Brendan's Hospital contributed Joseph Lalor, Conolly Norman, and John Dunne as presidents of the organisation, in its successive forms. More recently, Professor Thomas Lynch was vice-president of the Royal College of Psychiatrists, which evolved out of the MPA.

Dr. Fleury and the Women of the MPA

Dr. Eleanora Fleury was the fourth Assistant Medical Officer at the Richmond Asylum in the 1890s. In 1890, she had become the first woman medical graduate of the Royal University of Ireland, after studying at the London School of Medicine for Women and at the Royal Free Hospital. She received her MD in 1893 and her name appeared on the list of candidates for prospective membership of the MPA put before Council in July of that year, nominated by Conolly Norman. The MPA president was then Dr. J.M. Lindsay of Derby. Among those in favour of Dr. Fleury's candidacy were Drs. Rayner (Harley Street) and Yellowlees (Glasgow), with Dr. Ireland (formerly of Stirling) opposing. A constitutional wrangle followed concerning the meaning of 'men'. However, Dr. Fleury was in fact elected the first female member of the MPA in 1894, though she was a poor attender at MPA meetings, and in 1895, her paper, '*Agitated melancholia in women*', was read for her by the President (Floate & Williams, 1991). By the turn of the century, there were 14 women members or former members; these included the first female president, Dr. A.H.A. Boyle (1939). However, women had been sitting the MPA's examination, leading to a certificate in psychological medicine, since it began in 1885.

Sir Dominic Corrigan found the concept of women doctors repugnant; he conceded that a few women might go for 'men's jobs', but pointed out to the General Medical Council in 1875 that it was inconceivable that a woman 'would go for the job of regimental trombone player' (Lyons, 1992, p.38)!

Admissions to the Richmond

The early practice in Ireland for admissions was by order of the Board of Governors, on application to them by a relative or friend of the alleged lunatic, or by another 'interested' person. Under an Act of 1821 (1 & 2 Geo. IV, c.33, ss. 16-18), those acquitted at trials on grounds of insanity or those unfit to plead – 'criminal lunatics' – were to be detained in asylums at the pleasure of the Lord-Lieutenant. In 1838, a Dangerous Lunatics Act was passed (1 & 2 Vic, c.27), following a murder committed by a patient who had been refused admission to the Richmond Asylum. Medical evidence was to be obtained if deemed necessary, but it was not essential. Dangerous lunatics or idiots could be committed to gaol until discharge was effected by two justices, or until the inmate, on the order of the Lord-Lieutenant, was removed to a lunatic asylum. Eventually, in practice, the RMS came to authorise most 'non-dangerous' admissions, which had to be endorsed by a magistrate or clergyman (as to the inmate's pauper status) as well as by one medical man. Under an Act of 1842, two doctors were required to authorise admissions to private asylums only, since nobody was assumed to benefit from pauper admissions. Inspectors had to put pressure on the authorities, however, to ensure that those gaol'd were ever reviewed. Patients admitted to gaol who were not paupers could be transferred to the public asylum (Chief Secretary's Office, Registered Papers 1861/6868).

Probably, some admissions were never seen by the justices who signed the committal forms, and some 'dangerous lunatics' had in fact committed only

trivial offences: over 25% of all admissions to public asylums in the early 1880s were by judicial committal. The 1867 Act (30 & 31 Vic, c.118) empowered justices to send dangerous lunatics to district asylums instead of to gaols, but a report from the local dispensary doctor was mandatory. The percentage of both sexes admitted to district lunatic asylums under the Dangerous Lunatics Act increased throughout the remainder of the nineteenth century, accounting for over three-quarters of male and almost 60% of female admissions. (In the Richmond Asylum, the figures for 1911 were: 75% of males and 40% of females.) This phenomenon may have reflected 'a greater difficulty in controlling intractable males outside the asylum and, conversely, a tendency for any female violence to be neutralised within the family' (Finnane, 1981, p. 101). Equally, it might have arisen from 'the susceptibility of males to prosecution for drunkenness'. Robins (personal communication, 1992), on the other hand, believes that the real reason was that it was easier for outside doctors to procure an admission in this way, because RMSs had to accept 'dangerous' cases.

Though the main intention behind the Act had been to prevent criminality, it in fact became the chief mode of committing the insane, despite the criticisms of both inspectors and asylum doctors. Lalor, however, believed that the Act was used properly, except for some instances of spitefulness on the part of relatives (Trench Commission, 1878-9). There was no mandatory review of the condition and status of a person detained under the Dangerous Lunatics Act 1838, and the Dangerous Lunatics Act 1867 treated the mentally ill and handicapped in substantially the same way as its predecessor (Finnane, 1981, p. 97). Under the Lunatic Asylums (Ireland) Act 1875, asylum managers could retake escaped inmates without fresh certificates within 14 days: attendants sometimes went after escapees, or if necessary the police were called in, and most inmates were in fact recaptured. Sometimes they were brought to the asylum bound in ropes, or injured from fighting with the escort. It was not unknown for people to be admitted in order to teach a salutary lesson about domestic violence, alcoholism, or infidelity, whether the 'lunatic' was victim or perpetrator (Richmond Asylum Male Case Book, 1888-9; Richmond Asylum Female Case Book, 1891-2).

RMSs were legally vulnerable if a patient was found to be illegally detained, unless admitted as a dangerous lunatic. The 1875 Act allowed for the correction of incorrect certificates within two weeks of the committal; this was a direct result of Joseph Lalor being fined £100 (*Medical Press and Circular*, 1871). In this respect, the ordinary lunatic was now in the same position as the dangerous lunatic.

Norman, writing in July 1899 to his Governors, stated that he could not admit a 'very dangerous suicidal patient . . . merely on [my] own request . . . a good deal of trouble was involved in enabling the case to be admitted in due course of law'. Only in 1945 were the committal laws amended to remove the process from the judiciary by putting admission in the hands of the medical profession, i.e. the RMS.

The first-admission rate for the Richmond Asylum in 1871 was the highest of all Irish district asylums. By 1911, this had risen by 130% to 6.52/10,000, but this compares with a mean increase for all asylums of 191%. Quite complex factors operated to produce this startling trend, e.g. declining population, lowered marriage rate, and emigration. However, by the 1980s, the population served by St. Brendan's had been dwindling rapidly from a peak when it accepted patients from the counties of Dublin (incl. Dublin City) and Wicklow, as well

as providing a resource for the homeless, the 'non-district' (those passing through the catchment area), and the very disturbed (a semi-official regional secure unit function). Eventually, it will provide for the Cabra and Finglas areas of Dublin only.

Discharges from the Richmond Asylum

Under the Dangerous Lunatics Act 1838, patients transferred from gaols to asylums by the Lord-Lieutenant's warrant could be discharged only by a Lord-Lieutenant's order, in response to a certificate of sanity signed by two doctors. Under an amendment in the law in 1845 (Finnane, 1981, p. 92), it became necessary that the patient had also ceased to be dangerous, and in the following year, the Lord-Lieutenant's involvement was no longer necessary. Henceforth, the discharge of dangerous cases was the same as for ordinary lunatics, i.e. by the Board of Governors, with a certificate from the RMS or visiting physician. Discharge could be to one's own home or to the workhouse. This procedure was embodied in a Law of 1867 (30 & 31 Vic., c.118, s.11), but there was no statutory provision for automatic review. The RMS could block the release of a patient, despite a relative's request for his/her discharge, but an inmate could write to Dublin Castle and have the case reviewed by the inspectors. However, if a person requested information concerning a prior committal, he ran the risk, according to Finnane (1981), of being seen as lacking in insight! Clearly, any legal recourse was financially inaccessible to paupers.

Population of asylums

Irish asylums, although built to hold a national total of 1,220, contained 2,028 inmates in 1843. A year later, it was estimated by the police that there were 6,217 "harmless idiots and simpletons" outside the institutions (Finnane, 1981, p. 34), though in his report on the future needs of the asylum system, Francis White, the first Inspector of Lunatics, described these persons as 'dangerous to themselves and the community' (Chief secretary's Office, 1845). Despite a falling population, the total number of beds in Irish district asylums continued to increase over the years.

The inspectors believed that there were two important reasons for this increase (*Journal of Mental Science*, 1874): the increased expectation of cure, leading to a greater tendency to have lunatics admitted, rather than hiding them at home, and their increased longevity because of the good care offered by the asylum. The same *Journal* (1879, p. 632) quoted from the 27th Report of the Inspectors (Irish Lunacy Blue Book for 1878):

It may be proximately assumed that one individual in about 2150 of the population is primarily attacked each year by mental disease, and as the recoveries or improvements justifying a discharge, and which occur at indefinite periods ranging from months even to years, may be estimated at 76 per cent, 24 would thus continue to be incurred; hence Asylums – making all the allowance for those who may die in them, or may be taken home by their friends –

TABLE 3

Asylum population

(a) All district asylums	
1851	2,802
1861	4,623
1871	7,831
1914	>21,000
(b) Richmond asylum	
1814	236*
1857	600
1871	1,040
1886	1,100
1896	1,398
1898	1,888
1904	3,218
1960	1,677
1980	942
1984	912
1990	350 (Dec.)**
1992	c.300

* See Loneragan (1984).

** See McGennis (1991).

Large differences in reported populations of the Richmond Asylum are to be found among different authors. This is only partly explained by the time of year (usually 31st Dec.) on which the census is taken.

must necessarily become overcrowded in the progress of a generation.

Sir Robert Peel, whilst Chief Secretary for Ireland (1812-1818), had decided against establishing new asylums for Louth and Wicklow (Finnane, 1981, p.39). However, a second asylum for Dublin, to supplement the Richmond, was being planned in 1894; land was acquired at Portrane to the north of the city, on which the present St. Ita's Hospital now stands. Initially, 50 patients were moved to an old manor residence on this site, but the new asylum was completed in 1902, with space for 900 (O'Shea & Falvey, 1984). The county of Louth ceased being served by Grangegorman in 1920, followed by Co. Wicklow in the 1960s (O'Shea *et al*, 1986).

In 1843, a parliamentary committee reviewed Irish lunacy provisions, examining the idea of a special, detached, secure unit on the grounds of the Richmond Asylum. However, the leader of the Irish judiciary, Sir Edward Sugden, wanted a separate facility. Dundrum Criminal Lunatic Asylum was opened in 1850, 13 years before Broadmoor Hospital, with beds for 80 males and 40 females.

The reasons for the fall in inpatient numbers in recent years are multiple: the opening of satellite hospitals, the activities of an on-site assessment unit (McGennis *et al*, 1983), community facilities and clinics, community psychiatric nursing, pharmacotherapy, and, to some extent, changes in social attitudes. A programme for homeless mentally ill males was established in 1979 (Fernandez, 1985) and a special resettlement team set up at St. Brendan's Hospital to place long-stay patients in more appropriate facilities (Mohan, 1990). Finally, an old age psychiatry service, the first formal one of its kind in Ireland, was started in north Dublin in 1989 (Wrigley & Gannon, 1990).

Mental Nurses (Attendants or Keepers)

In 1851, Dr. W.A.F. Browne of the Crichton Royal Hospital started the first organized course for attendants in Britain, whilst Dr. Thomas Kirbride of the Pennsylvania Hospital had already introduced a course of instruction for attendants in 1843. The first training school for attendants of the insane was started by Dr. Abraham Cowles of the McLean Asylum, Massachusetts; its doors opened in 1882. Another school was founded at Buffalo State Hospital the following year. During the 1890s, Conolly Norman insisted that attendants seeking promotion should pass an internal examination. The *Handbook for the Instruction of Attendants on the Insane* had first been published by the MPA in 1885.

In the latter half of the nineteenth century, the salaries of Irish attendants and nurses were between one-third and one-half those of their English colleagues. The Richmond Asylum had five night attendants in the male and five in the female house. Suicidal, epileptic, and sick patients were located in three separate wards, each provided with one attendant, though extra attendants were 'freely used with special cases' (Burdett, 1891).

In 1895, the Asylum Workers Association was formed in Britain; though its main aim was to promote the interests of nurses and attendants, some doctors and clerks joined the organisation. Membership was so low that it opened its doors to Irish workers in 1909, though the Irish response was equally poor (Robins, 1986). In September 1911, the Association published a denial of its trade union status in the *Irish Times*. It had, however, won pensions for some long-serving staff. An Irish Asylum Attendants Executive was set up at Maryborough Asylum in 1911; this movement spread to other asylums, but achieved little. In 1917, the Asylum Workers Union, formerly the Irish branch of the British Asylum Workers Union, was formed in Dublin to represent the majority of asylums, and there followed a few years of trade union militancy in favour of better wages and conditions. In 1924, however, when staff went on strike, the authorities simply replaced them.

1919 saw the formation of the General Nursing Council of Ireland (now *An Bord Altranais*) to standardise and supervise training and register qualified nurses. Initially, if a nurse had the RMPA certificate, automatic registration was assured, but after 1935, it became necessary to pass the Council's own examinations. Individual mental hospitals now had to be recognised as being suitable for training before a candidate could be accepted for examination. Today, individual wards and community facilities may be refused the status of training areas if found to be unsatisfactory. The four nurse training schools of the Eastern Health Board were amalgamated in 1987.

Diagnostic Practices at the Richmond Asylum

An examination of the records of 50 consecutive male admissions to the Asylum during 1888 showed a similar distribution according to ICD-9 diagnoses to that of 1980 in the same institution, despite the archaic labels then in use (Falvey & O'Shea, 1983). The only exception was a lower incidence of alcoholism in the earlier cohort. Fr. Theobald Mathew (1790-1856) had created a national temperance movement in 1838, which was highly effective in the short term:

the production of whiskey more than halved during the 1840s. However, this change was not maintained. In 1893, about 9% of admissions to asylums was related to alcohol, but this rose to 15% between 1896 and 1906, whilst in 1982, the figure was 25%. 'A wider extension of the Inebriates Act' was called for by the Asylum Board in 1900, so that multiple-admission alcoholics could be managed 'in an institution specially designed for the purpose'.

There were many epidemics of cholera particularly in 1831 and 1832. In Dublin in 1831, 5,632 out of a population of a quarter of a million died from cholera. The Richmond Penitentiary (on the opposite side of the Rathdown Road from the modern St. Brendan's Hospital) was reopened in 1832 to house victims of the epidemic (O'Shea & Falvey, 1984). Dysentery (e.g. the Richmond epidemic of 1891) and typhus commonly occurred in epidemics within asylums.

GPI was relatively uncommon in Irish asylums in the earlier part of the nineteenth century, especially outside the cities, but it became a frequent cause of male deaths in the Richmond and other urban asylums towards the end of the century.

Masturbation was seen as a cause of mental illness, and a declaration of abstinence could be viewed as a sign of improved mental status (Richmond Asylum, Male Case-Book, 1888-9). Tissot's (1728-1797) belief in the hereditary transmission of madness secondary to ancestral onanism were well received in nineteenth-century Irish professional circles. Religious delusions were often taken as evidence that excessive religiosity was the cause of insanity; many RMSs were Protestant, whereas in most parts of Ireland the bulk of their patients were Catholic (Finnane, 1981).

The asylum had four outbreaks of beri-beri between 1894 and 1898 (O'Shea & Falvey, 1984), although previous outbreaks were not unknown. Since contemporary wisdom had it that this was due to overcrowding, extra space and a new wing were made available in the adjacent Richmond penitentiary. This wing was removed in 1937 to make room for the current Nurses' Home. Beri-beri was a source of considerable anxiety for Conolly Norman: 'there are still no less than 140 cases . . . under treatment in the female hospitals, the charge of which means an immense amount of work and anxiety . . . The mild and somewhat aberrant cases do not unfortunately preclude the possibility of sudden death [from heart disease]' (Norman. Letter dated 24.2.1898). And: 'One of the nurses who suffered severely from beri-beri in the year 1897, and who since her recovery has been employed at Portrane, has again become ill and . . . under treatment' (Norman. Letter 19.1.1899).

Dr. Walter G. Smith, President of the Royal College of Physicians, and Physician-in-Ordinary to the Lord-Lieutenant, wrote to Norman in October, 1896: 'Apart from the fact of the lamentable overcrowding, and the possible lurking of infection in the woodwork of both the old and the new buildings, no fresh light has been thrown upon the etiology [*sic*] of this singular disease, which has hitherto been recognised as originating in the British Isles'. Smith felt that the malady was 'evidently an epidemic and infectious disease'.

Physical morbidity was very pronounced in the peri-Famine era, even among the young (Finnane, 1981), who often died shortly after admission, particularly from pulmonary tuberculosis the single most important cause of death in Ireland in the early twentieth century. Indeed, Crookshank (1899) postulated that institutions might be propagating the disease. A retrospective case-note study

in the early 1980s of 200 consecutive male admissions (all under 65 years of age on reception) to three psychiatric hospitals, including St. Brendan's, in which patients were classified as of no-fixed-abode, urban, rural, and semi-rural, showed that all groups still had a disturbingly high level of physical morbidity (O'Shea *et al.*, 1983).

The Asylum environment

In the nineteenth century, the atmosphere was one of strict discipline, with the RMS at the top; 'moral treatment' aimed at removal of the patient from unfavourable extramural influences and his/her subjection to healthy ideas. Asylums had large farms, which offered an open-air occupation for many inmates, so that food was relatively good, in comparison with workhouses and the general community, including fresh vegetables. Burdett (1891, p.243), however, did not think much of the size of Irish asylum farms, stating that the 'dietary in use in the Irish asylums, and the clothing of the patients, are very inferior to those of English institutions.'. He also reported (p.243) that 'the bareness of the wards and the absence of furniture' struck an English visitor. By Irish standards, the Richmond Asylum issued liberal amounts of alcohol to inmates, but this was drastically curtailed after the MPA encouraged the abolition of alcohol in asylums (*Journal of Mental Science*, 1884).

Dr. E.M. Courtenay, the RMS of Limerick Asylum, found that meat was given 'in excess' in English asylums:

bread, milk and potatoes form the large part of the dietary in this country . . . the food given in Irish asylums is to be commended on one point, and that is for its bulk. . . . We must, of course, allow that it results in a certain degree of waste. . . . But dealing as we do with an agricultural people, always accustomed to live on the produce of their own land to a very large extent, I believe they are much more contented on a farinaceous regimen than on animal food. . . . One article of food has increased in favour with the Irish more than perhaps with any other people, namely tea. (Courtenay, 1886, pp. 20-1)

In June 1831, following their inspection of the Richmond Asylum, the Inspectors of Prisons, Majors Benjamin Woodward and James Palmer, described the asylum as being very dirty and that many cases of restraint had not been properly recorded. As noted above, this report led to the dismissal of Dr. Heisse. The latter, aggrieved by his removal from office, wrote to the governors of the Richmond that he was 'utterly ignorant of the charges against' him. He blamed the warm weather for the excitement of his female charges and their consequent need for 'more restraint than usual'. He went on to plead that 'with respect to the patients being in bed, with the exception of cripples and females kept in bed for obvious reasons, I refer the board to the medical officers to these under treatment' (Reynolds, 1992, op. 49). As regards the shortage of clothing and shoes, Heisse reminded his employers that he had 'previously reported the want of both'. With reference to the dirty state of the wards, the ex-Moral Manager explained that the Inspectors had arrived at

an unfortunate time, the period between the delivery of the weekly allowance of coal and straw and the sounding of the bell 'for the servants to commence cleaning the house'.

In 1856, Samuel Wrigley reported that one of the two ball-courts at the Richmond Asylum was occupied by the apothecary's pigs. The physician regretted that there was little to occupy the minds of its inmates (House of Commons Papers, 1857-8, xxvii). Inmates were often kept in hospital because they proved to be useful workers: women usually worked at sewing, cleaning, laundering, and in the kitchens.

In response to numerous complaints about the conditions prevailing in Irish asylums, the government appointed Dr. James Wilkes of Stafford and T.L. Donaldson, a London architect, to investigate these matters. In their report of 1855, the two commissioners criticised the severe economy and lack of comforts for the inmates. Heating was inadequate in the Richmond, windows were often unopenable, ventilation was poor, and the furniture was scanty and of poor quality (Commission of enquiry, 1855).

In 1862, at a ball held for Richmond Asylum patients, the aldermen of Dublin City were struck by their docility (*Irish Times*, August 1, 1862). However, when Daniel Hack Tuke visited the asylum (*Journal of Mental Science*, 1875), he commented favourably on the use of schoolteachers by Dr. Lalor who had also introduced industrial employment and gymnastic classes. Lalor's interest in education for lunatics, and his call for its sponsorship by the state stemmed in part from his visit to 'the admirable institutions at Leavesden' (Lalor, 1877, p.420). In his annual report for 1862, Lalor listed the amusements available to the patients (Reynolds, 1922, p. 136). These included backgammon, cards, chess, croquet, dancing, darts, football, handball, music, singing, walks in the garden (some women walked to the Phoenix Park), and a variety of books, magazines and newspapers, for example *The Illustrated London News*, *Fun*, *Irish Freeman* and *The Irish Times*. *The Irish Times* commented on 26 August 1864 that 'Twenty years since, he would have been consigned to Bedlam who permitted the insane to "run in sacks", organise brass bands, and figure in reels and country dances'.

Norman's concerns also included the quality of his charges' sleep: 'I have directed the storekeeper to pay special attention to the quality of the wire mattresses which are being affixed to our old beds' (Norman. Letter, October 13, 1898).

There was the occasional murder of one inmate by another, but because of the size of the campus and the quality of attendants, such incidents might not be discovered for some time. Also, a lunatic's evidence was controversial when these cases were investigated (Chief Secretary's Office, Registered Papers, 1889/21627). Restraint, though, was not confined to institutions; patients were often restrained at home, being later admitted with bruises and fractures (Chief Secretary's Office, Registered Papers, 1894). Norman wrote to J. Lowndes, the Inspector of Asylums, who had quoted Griesinger as saying that non-restraint in England was more calming than was restraint in Germany in 1845: 'in the time of my predecessor [Lalor] in office this Asylum led the way in this country, not only in doing away with mechanical restraint, and in limiting seclusion, but also in the occupation of the patients'. However: 'those who cannot work necessarily spend their time pacing up and down in our restricted recreation

ground, virtually, as I have said before, on the same spot for years' (Letter, May 21, 1895).

Donelan, like Norman before him, objected to the grounds of the hospital being overlooked by people from the neighbourhood. In a report to the Richmond Visiting Committee in August 1918, he particularly complained about the owners of cattle sheds who had built these structures against the asylum wall. Donelan demanded their removal, the Law Agent was instructed to have the wall raised at the expense of the shed owners, and the matter seems to have been settled. The boundary wall was often lined by outsiders on Sundays, a source of much annoyance to those inmates who made use of the grounds for leisure. Among Donelan's concerns were the lack of suitable dinner wagons to facilitate the service of meals in the dining halls, the adaptation of bed clothes 'to meet the variations of the seasons', and the provision of emergency exits in temporary buildings (Report of RMS, 1909).

The Mentally Handicapped

The first Irish asylum for the mentally handicapped, the Stewart Institution for Imbecile Children, was opened in 1869. Situated in Palmerstown on the western edge of the city, this hospital still offers an excellent service.

The Bedford Asylum for Children was established in the Asylum grounds in 1805 by the House of Industry to take a thousand children, irrespective of religious affiliation. They worked at various crafts, until local businessmen objected, on the grounds that their profits were being seriously interfered with. Nothing now remains of the building save its foundations (O'Shea & Falvey, 1984). In 1901, Norman called for the establishment of idiot asylums: "Idiot and imbecile children are unfitted for association with adult lunatics, and are quite unsuited for workhouses or ordinary asylums, where no means can be provided for teaching them and eliciting whatever powers they may have" (Letter, February 21, 1901).

Other considerations

The Richmond case-books have been described as being 'particularly rich in recording the behaviour and even language of the inmates' (Finnane, 1981). Burdett (1891, p.258), however, recorded that 'in most asylums notes and records of cases have hardly been kept at all . . . it is not known that there is a port-mortem book kept in any asylum in Ireland'. The *British Medical Journal* (1891) reported that the inspectors were concerned at the lack of post-mortems in Irish lunatic asylums – 'With the exception of the Richmond Asylum they are hardly known'. Regrettably, the quantity and quality of the records of St. Brendan's Hospital, and of many other Irish institutions, have declined considerably, even in recent years. This lamentable situation is due to their dispersion, and to the deplorable state of some of the attics, basements, and out-houses wherein the remainder have been left (O'Shea *et al*, 1986).

Irish asylums have had plenty of critics during their long history, one of the most vitriolic being Dr. P. Moran (1930). He considered that the buildings dated to a period when 'detention was the only object', so that they were 'architectural atrocities', more like 'gaols rather than hospitals. The best aspects of the buildings are occupied by corridors'. Ventilation and sanitation were poor, the buildings grossly overcrowded, the medical staff few in number and 'scandalously underpaid', while attendants had not yet developed the attitude of mind required of a mental nurse. The dietary was inelastic, cooking was central and by 'mass production', and, perhaps worst of all, was done by an 'amateur'. The attitude of the general public to them and of the local boards was described as apathetic and indifferent.

Burdett (1891, p.242) considered the cost of Irish maintenance to be generally low, in comparison to English asylums, and blamed this on small salaries, cheap labour, and 'a spirit of economy . . . not elsewhere . . . considered consistent with due provision for the insane'. In 1990, the cost of the service based at St. Brendan's Hospital was £12,000,000, of which the hospital took up £8,000,000 and the community services £4,000,000. Comparison with other services is impossible because the hospital's role is in a state of transition from district asylum to serving a smaller population, and because of the division of expenditure between Health and Social Services in England. The present staffing, for 19 wards, includes 15 consultants and 22 junior doctors (Anonymous, 1991).

Conclusions

The House of Industry, which owed its foundation to an Act of George III (1772, 11 & 12), and which later became the Richmond (General) Hospital (1812; surgical), formed, with the Whitworth (1818; medical or 'chronic') and Hardwicke (1803; fevers) buildings, St. Laurence's Hospital until recently. It has been closed and incorporated into the new Beaumont Hospital, itself called after an Englishman, despite the fact that Corrigan's pulse found life at the bedsides of the Richmond unit. If one says 'the Richmond' in Dublin today, it will be assumed that one is referring to the general hospital, the earlier title of the 'Gorman' or '(W)Rigley's Asylum' having been forgotten. The Lower House, the original Richmond Asylum, with its arches to allow access for horse-drawn supplies, closed in 1989. Wards continue to close in St. Brendan's Hospital, and the intention is that eventually, this should happen to the whole campus (Walsh, M. 1991. Personal communication.). Despite its continuing legal status, the title of RMS has fallen into disuse during the last few years. Instead, the executive medical administration has been undertaken by part-time Medical Directors, Drs. James O'Boyle and Angela Mohan. Theirs is the task of seeing out the hospital which, more than any other in Ireland, has shared the growing pains of our College, often at its helm.

Ireland took more readily to the Poor Law than did Britain (Longmate, 1974). It also took quickly and early to the establishment of a network of asylums (Finnane, 1981). It has already started down the uncertain road to

community-based psychiatry, leaving behind the structures of another day, a different world.

Acknowledgements

The authors wish to thank Susan Floate of the Royal College of Psychiatrists Library, London, and the Librarian, University College Dublin, for their patience and help. Dr. Joseph Robins read the manuscript and offered helpful comments.

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21 'The early treatment of Mental Disorders': R.G. Rows and Maghull 1914-1918

BEN SHEPHARD

'We simply love your book': soon after the publication of *Sherston's Progress*, in September 1936, Siegfried Sassoon had a fan letter from Miss Katherine Rivers. She was especially pleased that, in the third volume of his fictionalised war memoirs, Sassoon had given her brother Will his real name: 'So glad you called him 'Rivers'. Now his name "liveth forever more" on earth' (Rivers Papers.IWM).

It does indeed. Thanks to Sassoon, W.H.R. Rivers has become part of the modern mythology of the Great War, the one 'shellshock' doctor everyone has heard of, the protagonist in two novels by Pat Barker, and the subject of a belated (if dull) entry in the *Missing Persons* volume of the *Dictionary of National Biography*.

Neurologist, psychologist, anthropologist, psychiatrist, repressed homosexual, and (briefly) politician, Rivers is certainly the most intriguing of the 'shellshock' doctors and the one who came closest to revealing his own thought processes. Nor does anything in the vast literature compare with Sassoon's narrative, with its recurring image of Rivers, wearily removing his pince-nez to rub his eyes as he listens to Sassoon's troubles; and its evocation of the corridors of Craiglockhart Hospital, stale with the smell of cigarette smoke and old fear, resounding at night to the cries of battle dreams.

Never mind that Sassoon was not the typical patient, or Craiglockhart the only such hospital; or that Rivers's work led ultimately up a blind alley. It was inevitable that when historians rediscovered shellshock they should be drawn – via Fussell (1975) and the war poets – to the work of Rivers and the other 'psychologists' – Myers, Brown, MacDougall; inevitable, too, that, in ordering a subject of huge complexity, they should revive the rhetorical distinction first made by Rivers and his contemporaries – between the humane, analytically-minded methods of the 'psychologists' and the authoritarian, sometimes brutal approach of more mechanistically-minded 'physicalist' doctors.

This approach produced some stimulating work (Leed, 1979; Showalter, 1985; Stone, 1985); but with time it has come to seem 'abstracted and distant' (Ritchie, 1986), more concerned to recruit 'shellshock' to the gender wars and neo-Foucaultian seminars of the 1980s than to establish its on-the-ground historical reality. Much of this writing is oversimplified and distorts the real issues of wartime psychiatry. As Leese (1989) has pointed out, only a minority of British

soldiers was treated by the doctors whose writings underpin the elegant modern theorists; there was much more to 'shellshock' than doctor-patient encounters and articles in *The Lancet*. But perhaps the main weakness of this first wave of writing is its blindness to what S.J. Gould has called 'the central principle of all history – contingency'.

A historical explanation does not rest on direct deductions from laws of nature, but on an unpredictable sequence of antecedent states, where any major change in any step of the sequence would have altered the final result. (Gould, 1989)

'Shellshock' is an episode where chronology matters. Medical opinion and official policy changed over the war, with experience and in the light of debate; what Charles Myers, F.W. Mott or William Rivers said or wrote in 1915 is not the same as what they said, wrote – or did – in 1918; a soldier who claimed to have been blown up by a shell would have been believed immediately in 1914, but not in 1917; a man shot for cowardice in 1916 would have been spared in 1918; a condition once labelled 'neurasthenia' had, by the end of the war, become 'anxiety neurosis'; even Sir Douglas Haig changed his mind (Babington, 1983). What is more, the order in which the various changes came about, the particular way in which military policy, medical knowledge, and public opinion interacted, had the effect of magnifying rather than minimising the terrible psychological effects of the war.

It is no accident that modern writers tend to ignore context and to write as if the medical polarities of, say 1917, were constant throughout the war. They are simply reflecting the fact that no adequate overall account of the shellshock episode was ever written. The 1922 War Office Report, though an indispensable warehouse of material, made only fitful attempts to impose chronology or to describe the stages through which the Army, the public, and the various species of doctors had passed in dealing with 'shellshock'; the account in the British *Medical History of the War* was fragmentary and unsatisfactory (Johnson & Rows, 1922). The one work which did try to explain how the various military and medical threads of the story were interwoven over time, the magnificent Australian history (Butler, 1943), was simply ignored.

It is time to fill that gap – not with another bold overall interpretation of 'shellshock' – feminist, ecological (Feudtner, 1933), etc – but with a narrative synthesis along the lines of Wilson's masterly *Myriad Faces of War* (1986). This chapter, like Leese's pioneering attempt to explore hospital records (1989) and Merskey's careful survey of the published literature (1993), is a step down that road. It seeks to integrate the available information on a single hospital, Maghull, to show how policy evolved there.

Roughly one in every fifty shellshocked soldiers was treated at Maghull – some 4,000 out of at least 200,000 (Leese, 1983) – but the hospital's importance to wartime psychiatry went much wider than that. A 'full history' of Maghull (Pines, 1991) can never be written – it had no Siegfried Sassoon or A.S. McDonnell among its patients, of its staff only T.H. Pear and Millais Culpin left recollections, and the records are fragmentary. But there is more than enough material to justify the venture.

The Red Cross Military Hospital, Maghull

Maghull Hospital no longer exists by name; but physically it still stands, a few miles to the north of Liverpool, part of a gloomy and controversial establishment, Ashworth Special Hospital, to which the criminally insane are sent. You can still see the red brick, two-storey, mock-Georgian villas where the patients lived, each with its steel-railed 'airing court' (or exercise yard) around it, and the low flat mortuary building, where the pathologists used to work. Moss Side House, the staff residence, has long gone.

Maghull was built in 1912, as a colony for epileptics – hence the gentler, more domesticated architecture. During construction, Liverpool Corporation which had various other establishments in the sombre, wind-lashed village of Maghull (just inland from the sands and links of Formby) had a change of heart and sold it, unused, to the Board of Control. Soon afterwards war broke out and it was commandeered by the War Office. In May 1915, Dr R.G. Rows was sent from the County Mental Hospital, Lancaster, to join the staff; soon afterwards he became Medical Superintendent.

Why was an obscure pathologist put in charge of this hospital? Richard Gundry Rows, usually known as 'Ronald', was born in 1867, the son of a Cornish educationalist – the name is pronounced 'Rowse'. He studied medicine at University College Hospital, entered the mental hospital system in 1893 and, after a brief spell in Birmingham, worked in several asylums in Lancashire, specialising more or less from the start in neuro-pathology. Rows began to publish in the *Journal Of Mental Science* in 1902 and by the end of the decade was a regular attendee of the Medico-Psychological Association's meetings (Orr, 1925a; Orr, 1925b).

The turn of the century was not an illustrious era in British asylum psychiatry. Rows would have agreed with Rickman (1950) that 'in those days asylum doctors, generally speaking, knew almost nothing of psychopathology, nor for that matter ordinary pathology; their laboratories and libraries were primitive, as was their cultural outlook.'; he certainly shared the general unhappiness at 'slow promotion, the obligation to remain single while an Assistant Medical Officer, and the routine nature of much of the work' (Lewis, 1969).

Rows made his feelings clear in an outspoken speech to the Medico-Psychological Association in 1913. Supporting the call for better training in psychological medicine he revealed that

he had been in four asylums but in none of them had he been associated with a colleague who was capable of teaching him the subject of psychiatry. And where should he have gone? In what British asylum could he have obtained adequate instruction in psychiatry? (Rows, 1913)

And, having himself carried out important research work, he was scathing about its place within the asylum system.

If since entering the lunacy service fifteen years ago, he had never opened a book on the subject of psychiatry, if he had never cut a section, if he had never looked down a microscope tube, and had never put pen to paper, he would yet be in the same position in the asylum service as he would be occupying today, the salary and the prospects would be the

same; indeed he was not sure he had not injured his prospects by the work he had done. (Rows, 1913)

But Rows's experience had also left him with a passionate belief in the other main plank of the reformist agenda – the need to break down the barrier between sanity and madness by supplementing the overcrowded asylums with urban clinics where 'borderline' patients could receive early treatment for mental disorders and thus, it was hoped, avoid 'the disaster of committal'. In the same speech, he recalled several cases of patients who had sought early treatment in asylums he had worked in, been turned away, and then taken their lives.

'Clinics' of this sort were, of course, beginning to spring up in Germany and the United States (and existed in Britain for a few private patients) In 1914, Rows described how, on a visit to clinics in Munich and Giessen run by Drs Kraepelin and Sommer, he had been astonished by 'the frequency with which we heard [the doctor going round the wards] utter the word "recovering" as we passed the patients'. 'What' asked Rows, 'do we find in this country?'

In the initial stages we neglect the patient, and when we cannot keep going any longer we call on the policeman or the relieving officer to carry out first aid. This consists often of dragging him from his home and landing him in a workhouse, and, if he becomes troublesome then severe restraint is applied. Then, at last having been coaxed to travel by the promise of three weeks' rest in a sanatorium, he ultimately finds himself under lock and key at an asylum. (Rows, 1914c)

The call for 'psychiatric science' to be made a branch of public health was one of the great liberal concerns of the day, spawning the Mental Hygiene movement in the United States. Politically and socially, Rows's analysis is not very sophisticated – there remains a touch of the provincial autodidact yearning for remedies known and idealised from afar. 'It was difficult' – he told the Association in 1914, while urging that research be better co-ordinated – 'for men who were away from the great centres of learning to get hold of the literature on the subject and to learn what was being done elsewhere. . . . The scientific journals were not within their reach, and as a rule, any journal they wished to see must be provided out of their own pocket' (Rows, 1914b).

To travel from remote Lancaster – where he alone kept the flag of scientific psychiatry flying – to Munich – where the subject was embraced with Germanic amplitude – was to glimpse the very gates of Rome. Several times in later articles Rows listed, with awe and envy, the lectures given in Munich in 1908 by Kraepelin, Alzheimer, and their colleagues – 'Clinical Experimental Psychology' . . . 'Normal and Pathological Anatomy of the Cortex of the Brain' . . . 'Methods of Examination of the Insane and so on' as the model to follow (Rows, 1912b).

In his own work, Rows's interests were at first austere neuropathological. Most of it, done with his friend David Orr, examined the mechanism of transmission of General Paralysis of the Insane (the field which F.W. Mott was also pursuing at Claybury), the influence of toxins on the central nervous system and the paths of infection through the lymph stream in the spinal cord. Orr, the pathologist at Prestwich Asylum, Manchester, had worked under Clouston in Edinburgh and was remembered as 'an indefatigable research worker', and a man of 'vivid personality' and 'buoyant optimism and enthusiasm' (*BMJ*, 1941).

In their thirst for knowledge, Rows and Orr even undertook the 'thankless drudgery' (Clouston, 1909) of translating into English a hefty survey of *Modern Problems in Psychiatry* by the Italian Ernesto Lugaro. Clouston, in his introduction, described Lugaro as 'ultra-modern in his views on insanity' wishing to 'sweep away the last vestige of the mistaken opinion that insanity is due especially to causes of a psychic nature'; throughout his work he sought to 'base it entirely upon organic processes and events'. Lugaro's ambitious attempt to bring together 'mental facts and brain organization', his emphasis on the 'pathogenetic importance of abnormal stimuli from organs other than the brain in causing psychoses', his tendency to minimise the role of heredity in mental illness and his distrust of a nosology based on symptoms were all to be important influences on Rows's later outlook (Clouston, 1909).

Shortly before the war, however, 'Freud's publications hit Rows like a tornado' (Pear, 1953). In 1911, he made a passing reference to 'the remarkable work of Freud and Jung, which shows us the importance of psychogenic factors in the production of neurasthenic and hysterical disorders' (Rows, 1912a), and soon afterwards he ventured out of the laboratory to experiment with psychotherapy. His bald statement in 1911, that 'patients suffering from mental disease should be kept in bed' in clinics, unless they were so 'excited' that 'prolonged bath treatment' was called for (Rows, 1912 a), gave way, three years later, to an ambitious paper to the Royal Society of Medicine detailing two cases of women in their thirties suffering from religious delusions. By patient and sympathetic investigation, Rows established that these delusions had been triggered by emotional shocks coming on top of the patients' 'abnormal psycho-sexual development' (one, a teacher, was a lesbian). Instead of drawing on Freud or Janet to explain their 'dissociation of the consciousness of the personality', though, Rows reverted to the pathology laboratory and plunged headfirst into an impenetrable thicket of 'feeling-tone' and 'organ-sensation' in which Wundt's theories of apperception and the writings of various now largely forgotten German and Italian psychiatrists were intermingled (Rows, 1914a).

Rows and the 1914 Report

Had Rows's reputation rested on this rather confused paper, he would hardly have been entrusted with Maghull War Hospital. It was his role in the internal debates of the Medico-Psychological Association which took him from obscure provincial malcontent to benign wartime impressario of the new psychiatry.

In 1911, proposals to bring in a Diploma in Psychological Medicine (and thus to raise standards in psychiatry) provoked mutinous noises from Assistant Medical Officers already working in asylums. On top of all their existing grievances, they were now expected to acquire an academic qualification. How could they afford to study? Would their committees give them time off? Having acquired the DPM, what were their career prospects? At a special meeting of the M-PA, Orr and Rows spoke out – on the specific grievances of the assistant medical officers and the need for early treatment of mental disorders.

The ensuing discussion showed that the membership of the MPA was split along the great philosophical faultline of the day. From the younger generation, Bernard Hart (then working at Long Grove and writing *The Psychology of Insanity*)

forcefully linked a call for change in the asylums – without which no able young doctor would wish to enter the profession – to a wider assertion of the ‘collectivist’ spirit underpinning the social legislation of the 1900s (Harris, 1994). While British psychiatry retained its humanitarian strengths, he said, it had lost contact with its scientific roots.

Scientific psychiatry in England is not on the same plane as it is in many other European countries. We have individual men who are working strenuously for the progress of psychiatry, but quite sporadically as it were; there is no organization of the science.

To those who urged the need for slow, patient progress without upsetting tight-fisted local committees, Hart replied tartly that ‘all those reforms which have been spoken of this afternoon could be carried through if this Association, as a whole, liked to exert itself.’ The status of the medical officer must be improved, and clinics where psychiatry could be taught must be established. Hart proposed that a committee should be set up, then and there, to recommend ways of implementing these changes.

The old elite of the Association spoke for a gentler, more individualist tradition. The status of AMO s was ‘a thing which cannot be dealt with for many years’ said Hayes Newington (a weary veteran of attempts to change the Lunacy Laws); nor was there anything wrong with good old British diversity; ‘anything like a central government of asylums’ would ‘kill progress in asylum work’.

Hart, though, received support from Hubert Bond, his superintendent at Long Grove, and from the suave and respected Maurice Craig (who had himself long since escaped the grind of asylum work). ‘How are we going to encourage men to take one of the various diplomas in psychological medicine now offered’, demanded Craig, unless the status of asylum doctors was improved. A number of these who had come to London for the meeting demanded action. Desperate procedural rearguard actions failed and a Committee on the Status of British Psychiatry was duly established, with Ronald Rows as its secretary (*Journal of Mental Science*, 1912). Three years later, after 4,500 miles of travelling, he was urging the adoption of its report.

The Committee’s recommendations were certainly ambitious. Clinics should be established at universities, medical schools, and general hospitals, to which patients could go for voluntary treatment without involving the apparatus of the Poor Law. These clinics would also function as teaching institutions for those entering psychiatry or already working in asylums. Career prospects for mental health professionals should be transformed, with a new career structure, enhanced scales of pay, the right to marry after five years, and facilities for study leave.

The reform campaign of 1911-14 produced, in embryo, the Maghull team: Rows, the asylum professional with a frustrated wish to promote early treatment and an eclectic interest in academic psychiatry; Bernard Hart, the sharp young intellectual, who in 1914 became Physician in Psychological Medicine at U.C.H.; and Maurice Craig, the backstage fixer, endeavouring to ‘hold the balance between older experience and the fascination of invading theories’. Craig is generally credited (alongside the neurologists Farquhar Buzzard and Aldren Turner) with persuading the War Office ‘that the mind was vulnerable as well

as the body, that so-called "shell-shock" formed and must form a part of the casualties of modern warfare and that such casualties required very special treatment and a very special organization' (Cameron, 1935).

'The Brilliant Band'

The British Army's response to the problem of 'shellshock' went through several stages and varied considerably as between France and Britain. It reflected, in many ways, the hard /soft split in the political culture of Edwardian England, between the culture of imperialism – of 'hierarchy, militarism, 'frontier mentality', administrative rationality, and masculine civic virtue' – and the current of domestic politics, 'running in quite the opposite direction, towards egalitarianism, "progressivism", consumerism, popular democracy, feminism and women's rights' (Harris, 1994).

That contrast was embodied in the two men who ran Army medicine for most of the war. In France, there was Sir Arthur Sloggett – a tough, rollicking extrovert and crony of Haig, who lived in a chateau and boasted of having the 'best dinner in St Omer with fabulous tales of his port and brandy' (Gilbert, 1975). Sloggett belonged more to the active than the cerebral tradition of Army medicine: he had survived being shot through the heart at the Battle of Omdurman in 1898 because 'It was in my boots' (*BMJ*, 1929). He knew little about neurology or psychiatry, had no interest in medical research, and reduced everything to the barebones of army administration, at which he ruthlessly excelled. This did mean that he had few professional allegiances and was prepared to consider any idea could see practical advantage in. (So that, when an epidemic of 'shellshock' developed on the Somme in 1916, he quickly took up Charles Myers's idea of creating 'treatment centres' near the Front and pushed it through the system). On the other hand, Sloggett knew the doctor's place in the Army hierarchy, accepted that all medical decisions had disciplinary implications, and was under constant pressure from the Adjutant-General. (When it became apparent in 1917 that Myers might resist the disciplinary role the Adjutant-General was demanding for the 'treatment centres', Sloggett quickly pushed Myers aside.) (*BMJ*, 1940; Myers, 1940; Cushing, 1936.)

In Britain, the reins were held by Sir Alfred Keogh – an intellectual as Army doctors went. Keogh had been Director-General of Medical Services before retiring in 1910 to become Rector of Imperial College, London; recalled to the War Office by Kitchener in 1914, his position was much more independent than Sloggett's and personally and temperamentally, he was close to Liberal politicians like R.B. Haldane; implementing Haldane's pre-war Army reforms, had given him the habit of involving civilian doctors in Army policy (*BMJ*, 1931; Haldane, 1928). Inevitably, Keogh took more heed of public and medical opinion than his colleague in France. To him, Lord Knutsford, the self-publicising chairman of the London hospital – who first drew public attention to the problem of the 'nerve-exhausted' soldier in November 1914 – was a valuable bridge to the voluntary sector; to Sloggett, he was an 'hysterical busybody' who went around 'stirring up Mare's nests', to be kept away from the Front at all costs (RAMC papers, Wellcome).

Maghull's career as a war hospital began in December 1914, in the first hue

and cry about the 'war damaged soldier' – when Aldren Turner was reporting on the many nervous problems in France, the psychologist Charles Myers was being appointed Nerve Specialist to the Army and, back in England, Sir William Osler and his colleagues were marvelling at the 'orgie of neuroses' that the war was producing (Cushing, 1925). At that stage, the emphasis in the literature was on hysterical symptoms such as blindness and deafness.

Keogh, beset by public and medical alarm, looked hurriedly round for a hospital where 'borderline' and 'mental' cases could be sent without incurring the stigma of the asylum. Maghull, 'being built upon the villa pattern', fitted the bill (Turner, 1916). The hospital had beds for 300 patients, expanded to 500 with the building of temporary huts in 1917. A small ward for 40 officers was opened in a nearby house in 1917, but most of the time Maghull was a hospital for ordinary soldiers. Officers had separate hospitals, mostly in London (Rowlands, 1985).

Until frontline psychiatry was introduced at the end of 1916, the British Army evacuated most of its psychiatric cases back to England for treatment. In theory, all passed through 'clearing' hospitals at Southampton and South London before being sent on to the appropriate 'neurological' hospital – Queen Square or Maida Vale for 'special but not prolonged treatment'; Maghull or Springfield (in Wandsworth) for 'severe or prostrated cases requiring more prolonged treatment'. In practice, though, most patients went into the general hospitals before the more fortunate were transferred to the specialist hospitals: cases of 'hysterical conversion' to Queen Square and those of 'neurasthesia' – or 'anxiety neurosis' as it came to be called after 1917 – to Maghull (Turner, 1916; Johnson & Rows, 1923). In the early days, there were also a good few psychotic and GPI patients at Maghull.

Maghull was, for Ronald Rows, 'not merely a new lease of life, but a new life' (Pear, 1960). It gave him everything he dreamed of – promotion from assistant medical officer, 'the opportunity to investigate a large number of those suffering from psychic disturbances during the early stages of the illness' (Rows, 1916), and the chance to create a psychiatric academy *a la Kraepelin*. He was fortunate that the Medical Research Committee shared his vision that 'in his hospital the psychoneurotic would obtain psychological treatment' (Pear, 1959). Born of the 1911 National Insurance legislation, the MRC represented an important pre-war power base for the 'organization of science', and its formidable secretary, Walter Morley Fletcher, was determined to pluck the experimental fruits of the war. A skilful Whitehall operator, Morley Fletcher pulled many strings in wartime medicine and usually made sure that there was a Cambridge man on the end of them (Fletcher, 1957; MRC: Elliot-Fletcher correspondence).

Feudtner (1993) has pointed out the kinship between the pre-war social reform movement and the wartime struggles to manage 'shellshock'. Both 'represent attempts to adapt the idea of responsibility to a new social order. The Liberal state and the psychological view of self – both fundamentally concerned with responsibility – were kindred developments'. It should be remembered that this battle to evolve 'psychological approaches to shellshock' was fought on two fronts and, on the more important front – the Army in France – ultimately lost. At home, it was another matter.

It was the MRC which sent academics to Maghull – 'the brilliant band of workers who at that time made [it] the centre for the study of abnormal psychology' (Orr, 1925). In the summer of 1915, Grafton Elliot Smith and

T.H. Pear – respectively Professor of Anatomy and Lecturer in Psychology at Manchester – arrived. Later in the year, they were joined by William Brown, Reader in Psychology at London, who had been treating soldiers evacuated from Gallipoli in Alexandria, and by William Rivers.

Elliot Smith had one of the liveliest medical brains of his generation. His tireless intellectual energy had taken him from Sydney to Cambridge, to Cairo, to Manchester, from the structure and evolution of the brain to the techniques of Egyptian mummification and the patterns of cultural diffusion in the ancient world – as well as to the problems of psychology and mental health (Wilson, 1938). He brought to Maghull a forceful personality and ‘an eager and unflagging spirit of inquiry’. The psychologists provided both theoretical background and some clinical experience. Before the war, Tom Pear had expounded Freud on dreams, ‘new and very exciting then’, to his university colleagues Elliot Smith, Niels Bohr, and Ernest Rutherford, and had listened while Elliot Smith criticised Freud’s uncritical acceptance of ‘old-fashioned theories of human instinct’. Brown had written on the use of hypnotism in the treatment of the ‘psycho-neuroses’ and Pear had worked for a time at the psychiatric clinic in Giessen (Pear, 1960; Culpin, 1952).

These academic heavyweights were bound to be interested in the problems posed by their patients – ‘I am doing real psychology here’ Elliot Smith wrote to a friend, ‘the work is extraordinarily interesting and instructive’ (Dawson, 1938). Their arrival produced, according to the Maghull records, ‘an important improvement in the work of the hospital. The patients are now highly appreciative of the attention paid to them’ (Rowlands, 1985). Maghull became a running symposium on the mind, ‘a society in which the interpretation of dreams and the discussion of mental conflicts formed the staple subjects of conversation’ (Rivers, 1922).

In this climate, it did not long go unnoticed that ‘patients who when awake, joked, played cards and billiards, [and] attended the dances’, also ‘raved and sleep-walked at night’, thus ‘giving the intelligent nurse the opportunity for revealing reports’ (Pear, 1960). One patient was heard to say in his dreams, ‘It was an accidental shot, Ma’or, it was not my fault’. Another’s dreams ‘always began with some terrible experience in the trenches and then turned to some sexual acts with women, usually with his wife and he woke to find the clothes disturbed and that he had “lost nature”’ (Rows, 1916). Elliot Smith noticed that many of the patients ‘when in dream states, become addicted to subconscious punning, reminding me of the part this tick played in the early development of the art of writing’ (Dawson, 1938).

The men themselves were naturally very alarmed by it all. ‘Questions such as “Why do I get these terrors?” “Why am I always seeing those things that happened in France?” “Why am I so irritable?” “Why do I get so upset?” are frequently heard from patients. In almost every instance the memory of some disturbing past experience will be found acting as the cause’ (Johnson & Rows, 1922).

Rivers at Maghull

These questions – the relationship between dreams, memory, and terrible wartime experiences, the role of repression; the relevance of Freud – would

ultimately bear their richest fruit in the work of Elliot Smith's friend and collaborator William Rivers. He came to Maghull in July 1915, soon after returning from anthropological work in the Pacific. Many years later, Pear recalled how:

with what seemed to be a jack-in-the box leap [Rivers] arrived with large suitcases prepared for a long stay. Perhaps this marked the beginning of a deliberate attempt to change himself from introvert to extrovert: he told me that he had decided that his cloistered life in Cambridge, interrupted by visits to simple people in the Pacific, as unlike ordinary persons as many university dons are, must cease. . . . Almost before he had unpacked Rivers . . . said he would like to be regarded as a student who had been away from books for a long time (the outbreak of war had found him for the second time visiting Melanesia) and wanted to catch up. Would I direct his reading for the next few weeks and on afternoon walks – Cambridge fashion – discuss it? His first desire was to grasp what Freud meant by the Unconscious which Rivers thought the most important contribution to psychology for a long time. Pear, 1960)

But Rivers took time to settle. His heart remained in anthropology; in the evenings at Maghull, he and Elliot Smith would discuss the theory of cultural diffusion (on which they had collaborated before the war) mystifying Pear with references to 'stone seats, megaliths, rags hung on trees, dragons, cranial deformation, circumcision, [and] mummification'. Nor, working with ordinary soldiers, did Rivers show particular gifts as a psychotherapist; he complained later that at Maghull he had 'little opportunity for testing dream-interpretation practically'; such of the men's dreams as he was able to get hold of were usually very simple and 'so far as they went furnished confirmation of Freud's view that dreams have the fulfilment of a wish as their motive. Thus, one soldier dreamt that he was sent back to the front, but directly he landed in France, peace was declared' (Rivers, 1923).

At the end of 1916 Rivers was transferred to Craiglockhart, a hospital for officers near Edinburgh. Only then did he come into his own.

Maghull as the Model

Rivers made no contribution to the first wave of published work from Maghull, which began to appear early in 1916. At a discussion at the Royal Society of Medicine, William Brown, by then in London, paid tribute to Rows's 'splendid enthusiasm for the method of analysis and re-education' and described several cases; Rows and Elliot Smith published articles (Rows, 1916; Eliot Smith, 1916). There was considerable overlapping of cases and only six patients were described.

A definite 'Maghull type' emerges from them. In all but one of the six, the problem derived from experience at the front, but said Rows, 'the incidents which have had such a disturbing influence have been those with which any emotional state is associated'. One man had shot another British soldier by mistake, a second had lost a comrade by his side, while a sergeant had broken down while on leave rather than face the responsibilities awaiting him in France. What was more, in most of them, the wartime episode had reactivated 'some

pre-war worry or emotion', which patient probing could uncover. A sergeant who felt guilty about his part in the retreat from Mons turned out to have been falsely accused of stealing as child; the man whose friend had been shot alongside him had had a similar experience in peacetime; a soldier so distracted by voices that he could not perform his military duties was, it seemed, still being chided by his siblings for a prewar visit to a prostitute.

Patients were treated by 'analysis and re-education', 'persistent reasoning and persuasion week by week', 'educating the patient in a simple way'. 'The physician', said Rows, 'should be prepared to give at least an hour for an interview and in most instances several interviews will be necessary, Short cuts may be attempted; they rarely lead to success'. The therapeutic Bible was Jules Déjerine's book on psychotherapy (which had appeared in English in 1913). Elliot Smith quoted Déjerine on the 'real therapeutic action of kindness' and 'the remarkable efficacy of common sense methods in restoring to those who are afflicted a normal attitude of mind'. There is no reference to hypnosis – of which Déjerine disapproved – and it would seem that Brown only took up hypnosis when he moved to London at the end of 1915.

Most of these early patients were regular soldiers, and Rows and his colleagues were astonished by the number who had apparently had an unfortunate childhood.

Many . . . seemed to have enlisted in the army to escape from a world which had been hard on them from their early years. Some had grown up with a lack of confidence in themselves, and they regarded the army as a haven of rest where, at any rate, they would be taken care of, could have little responsibility and would not be called on to exercise much initiative. (Johnson & Rows, 1923)

Their ignorance, too, came as an 'amazing revelation' to Elliot Smith, the learned polymath. The patient who had nocturnal emissions had to be convinced that they would not 'affect [his] brain and drive [him] mad (as 'trashy' adolescent literature had led him to believe)'; and that he was not 'tainted' by his father's criminal record (as 'popular writers on heredity' had persuaded him). When the 'structure and function of the sexual organs' were explained to him 'in an elementary way', he exclaimed 'Why wasn't I taught this when I was a lad; for then I should have been spared all this trouble?' (Elliot Smith, 1915).

No recollections by patients themselves have survived, but Rivers records that

the idea had got around that dreams were being used by medical officers as means of testing whether their patients were to be sent back to France, and it was only rarely that one was able to obtain more than the merest fragments of a dream. (Rivers, 1923)

This suggests that the men remained well aware of Maghull's role within the military apparatus of the war and, while flattered by the doctors' attention, were (rightly) suspicious of their motives.

Maghull was a military hospital, not a research establishment; its job, in theory, to return men to the front. The destruction of War Office records in 1940 makes it difficult to know what pressure was exerted – or whether the hospital was seen

in Whitehall as a public relations showpiece. Pear recalls criticism by fellow members of the RAMC for tending at times to forget the 'A' in their title.

In the early days . . . inspections by the type of Brass Hat who professed to think that all the half-thousand patients were 'skrimshankers' and malingerers, though infrequent, did happen. The little colonel [Rows] had his way with these visitors. After giving them a good meal, he saw that they got the full treatment: a leisurely tour of mental defectives, schizophrenics and maniacs. (Pear, 1959)

According to Ross (1941b), the military authorities 'slowly and reluctantly' came to the conclusion that it was useless to return men with chronic neurosis to front-line duty. 'A medical general came almost secretly to the hospital . . . and said would we please discharge as many from the army as possible, though we must not say he said so'.

This might explain why, in the year to June 30, 1917, only 20.9% of the 731 discharges from the hospital returned to 'military duty', while 65% went back to civil life, 12% to other hospitals, and 1% to civil mental hospitals (Salmon, 1923). After the war, Rows acknowledged that 'the further the invalid soldier went from the front line the more difficult it was to get him back to it'. Having crossed the Channel, he felt 'a sense of relief, a sense of safety, a feeling of escape from the terrible conditions on the other side, and quite naturally there arose a desire not to return' (Johnson & Rows, 1921).

They were terrified at the thought of going back; they loathed the idea that they might be considered cowards. If, however, their confidence was gained, and they saw that the doctor did not think anything derogatory about them, and if he assured them that as soon as they were better he would do his best to get them out of the army and back to civil life, their improvement was often rapid or striking. (Ross, 1938)

If Maghull could not overcome the inherent contradictions of military psychiatry, it was still almost unique among British hospitals at the time in showing sympathy and understanding towards the men – as the hospital's confident and articulate staff were well aware. Grafton Elliot Smlth, an incorrigible polemicist who loved a fight was soon tempted into print, comparing Maghull's successes with the hostility and lack of interest in psychoneurotic cases shown by doctors in general military hospitals and 'certain neurologists' (Smith, 1916). Gratified by the initial response, he (and Pear) quickly produced *Shell Shock & Its Lessons* which came out in 1917.

Their book was dedicated to Rows and inspired by his vision of a new psychiatry. After giving a brilliant popular explanation of shell shock and its treatment by 'psychological' methods, it hammered home the wider social implications of what had happened. Firstly,

the war has shown us one indisputable fact, that a psychoneurosis may be produced in almost anyone if only his environment be made difficult enough for him. It has warned us that the pessimistic, helpless appeal to heredity, so common in the case of insanity [is no longer adequate]. In the causation of the psychoneuroses, heredity undoubtedly counts, but social and material environment count infinitely more.

Secondly, the case for reforming the mental health system, strong before the war, was now overwhelming. The war had 'forced upon this country a rational and humane method of caring for and treating mental disorder among its soldiers' and, in the process, shown that the early treatment of mental problems, long advocated by reformers, actually worked. Those arrangements must be presented in peace, and Maghull became the blueprint for the future. When it came to spelling out details, however, the authors (knowing nothing about the administration of psychiatry) simply reworked Rows's pre-war articles and reports.

Shell Shock & Its Lessons got a predictably hostile reception in some quarters. Its attempts to fan the embers of the pre-war 'nature-nurture' controversy drove Dr Robert Armstrong Jones to restate his view that hereditary weakness of the nervous system was the main ingredient in shell-shock – to which Smith and Pear replied that he was branding 'some of the best and noblest member of our race' with a 'wholly undeserved stigma' (Jones, 1917). His Claybury colleague, F.W. Mott, set his juniors investigating the family history of his patients (Wolfsohn, 1918).

But Smith and Pear's real target was the general public and there the book's effect was enormous. It was partly a matter of timing. The first clouds of uncertainty about 'shellshock' had still not quite cleared; British neurologists, though becoming clearer about the issues, were still preoccupied by arcane medical debates across the Channel, peppering their publications with references to the rival French neurologists. Elliot Smith offered certainty, confidence, a common-sense tone – and clear, classical prose. The lack of hard evidence, the deliberate blurring of complex theoretical issues, and the very vague clinical picture were not much noticed.

This public relations coup coincided with two important developments: the American entry into the war and the pensions crisis of 1917. In May 1917, the US War Department sent Dr T. W. Salmon to England to see how 'war neuroses' should be treated. Although Salmon did not visit Maghull himself (leaving that to his colleague J. T. McCurdy), he absorbed the Maghull line in London and his subsequent report (a valuable snap-shot of British wartime psychiatry) endorsed the psychogenic view.

The psychological basis of the war neuroses is an elaboration with endless variations of one central theme, escape from an intolerable situation to one made tolerable by the neurosis . . . Not only fear . . . but horror, revulsion against the ghastly duties which sometimes must be performed, emotional situations resulting from the interplay of personal conflicts and military conditions, all play their part in making an escape of some sort mandatory. (Salmon, 1929)

Of more immediate importance in Britain was the change in official thinking on the subject of pensions. By 1917, it was becoming apparent to Keogh at the War Office and to Sir John Collie, medical advisor to the new Ministry of Pensions, that the policy hitherto adopted by most hospitals and boards towards 'the nerve-shattered' soldier – discharging him from the Army at the first opportunity, unless he was considered capable of further military service – was going to cost the country a fortune in pensions. Maghull on the other hand, appeared to be achieving an impressive success rate in 'curing' such

patients before discharging them. The obvious solution was to create more hospitals along Maghull lines and to recall as many patients as possible for further treatment (which would hopefully get them off the state payroll).

The only problem was the chronic shortage of doctors with training in psychological medicine: the war, Aldren Turner admitted, had 'revealed some lamentable defects in our medical education' (Culpin, 1948). And so, at the end of 1917, Keogh agreed to set up at Maghull a three-month training course for Army psychiatrists (or 'neurologists' as they were called). In all, 56 RAMC officers, six Canadians, and five Americans received instruction there before the end of the war.

'Such a short course', Rows admitted, 'was insufficient to teach the subject of mental diseases and their treatment, but, as far as the time would allow, the officers, by lectures, demonstrations and clinical experience, were trained to undertake the care of such cases' (Johnson & Rows, 1923). The lecturing at Maghull was mainly done by Pear, Rows, and Bernard Hart (who had arrived in May 1917), but William McDougall, Charles Seligman, Henry Yellowlees, Edward Mapother, and T.A. Ross also spent time at the hospital in 1917-18. (Ernest Jones never did; his pre-war scandals still made him *persona non grata*.) Presiding over this battery of talents, Rows was 'eclectic, wishing his lecturers to discuss not only Freud but Jung, Janet, Déjerine and Morton Prince' (Pear, 1960). Partly, this reflected Rows's own catholic tastes, and partly the greater complexity of approach which was developing at Maghull.

By 1917, the clinical literature of the war neuroses had evolved. The typical patient was no longer the dramatic case of hysterical conversion or the soldier with an old emotional problem brought out by the war; often, he was an apparently 'normal' person who, after several years at the front, living with fear, had simply had enough.

As the war went on [wrote Rows] it was not infrequent to find men who had done one, two or three years' hard service, but for whom the strain had at last proved too great. Often in these cases there had occurred some other incident, such as illness or some serious occurrence at home which had acted as disturbing agent, and then the strain had been felt more acutely. The fact that they had broken down was a cause of sincere distress to them; they were filled with shame and with disgust at their condition. (Johnson & Rows, 1921)

These cases raised questions for which the simple Maghull model of 1916 – rational persuasion à la Déjerine – proved inadequate (Also, its leisurely rhythms may have been coming under pressure). Some British doctors, like William Brown and Charles Myers, turned to Janet's theory of dissociation. Rivers, at Craiglockhart, was beginning to apply Freudian ideas of repression to explain how ghastly war-time experiences, absorbed into the unconscious, gradually brought a man to a grinding halt. The overall formula of the war neuroses as born of a mental conflict between a soldier's instinct for self-preservation and his sense of duty (which David Eder (1917) was the first British psychiatrist to employ) became increasingly common.

It is interesting to compare different verdicts on Maghull at this time. Charles Myers, looking in at the end of 1917, clearly found the heady theoretical mix more than he could take, reaching

the definite conclusion that I could never owe allegiance to any of the various schools of psychoanalysis or of psychotherapy, preferring to recognize the partial truths in each and to refuse acceptance of their wild and mutually antagonistic generalizations. (Myers, 1930)

Mapother, after two and a half years of surgery in France and Mesopotamia felt that Maghull was too soft and indulgent of the men. The maintenance of discipline and the conduct of an orderly room were, he later noted sarcastically, 'by no means the least important department in hospitals for neurotics'. While 'the vast majority of war neurotics were decent men who were genuinely disabled, the shell-shock hospitals contained more than their share of men with very little moral sense'. He thought the 'wave of sentimentality' which had swept the country during the war had made the 'sane' handling of the war neuroses more difficult, and recalled how an account of an epidemic of war babies in a Liverpool paper, was followed by 'correspondence demanding exemplary punishment of the harpies who were sapping the morals of our brave boys in blue – that is, the war neurotics from a neighbouring hospital [i.e. Maghull]' (Mapother, 1935). For the rest of his career, Mapother had a 'distrust of galloping speculation and abstractions' and a scepticism towards psychotherapy which he passed on to his protégées William Sargant and Aubrey Lewis. 'If psychotherapy is to become rational and to define its limitations', he wrote in 1932, 'then uncontrolled clinical findings must clearly be supplemented by observations as to the effect of standard experiences under experimental conditions capable of repetition' (Lewis, 1969). As for military psychiatry, his view was clear – 'in war everything must be subordinated to the winning of it' (Mapother, 1935).

A similar sense of a gulf between those with experience at the front and those without comes through in T.H. Pear's account of a debate in 1918, when William McDougall was briefly at Maghull. There was a staff discussion of the nature of conscience and religious imperatives, prompted probably by a case of Pear's.

A regular soldier in a famous regiment, who in peace-time while stationed in the East had loved his work, his comrades, his officers and the simple natives, and was a believing Christian. In the trenches, where he had expected to develop patriotism, he soon witnessed German atrocities followed by more savage ones by his own side. He had seen serious insubordination, read of the Easter rebellions in Dublin, and brooding on this, had concluded, 'Our lot are no better than the Germans'. When he arrived at Maghull, consumed by bitterness he presented almost a psychotic picture.

In the discussion about the proper therapy for this serious breakdown (which seemed to some of us unsurprising), McDougall, taking the attitude, 'why should fuss be made about a temporary loss of beliefs that were obviously right?', remarked that in France one of his patients had developed similar doubts. 'What did you do?' asked an American psychiatrist. 'Talked to him sensibly for an hour or two,' was the calm reply. 'Your sense, presumably,' said the American. (Pear, 1960)

Yet Millais Culpin, who had had his 'fill of surgical work' in France, got a lot out of Maghull. He had seen for himself that many symptoms diagnosed as organic were in fact psychological, and went to Maghull (at Aldren Turner's urging) 'armed with scepticism but compelled by curiosity'.

I soon knew that Captain Bernard Hart, Professor Pear and Major Rows had something to teach me. I had read a brilliant article by Mercier ridiculing Freud's theory of the unconscious and not a word on the other side. That theory, honestly and impartially set forth, among others, now gave me the key to many of my perplexities. Janet's theory of dissociation I have always been able to accept as a useful alternative, not contradictory, in one group of cases. Neither however dealt with what I still believe often happens – the cultivation of an hysteria that could be arrested by early recognition and simple handling. The spirit of Maghull was such that I was encouraged to give my own ideas about this. (Culpin, 1948)

No one, though, prepared Culpin for the hostility he would meet when he tried to apply these ideas in the outside world. His course at Maghull was abruptly cut short when a hospital in Birmingham became overcrowded with 'war neurotics' evacuated from London and Culpin and a colleague were drafted in to deal with them. They soon found themselves openly at war with their medical colleagues, to whom the patients 'when not insane, were liars and malingerers', and they, 'credulous fools for taking them seriously'. Eventually, he was transferred to another hospital at Ewell and became one of the most distinguished of the 'shell-shock' doctors (Culpin, 1948).

By contrast with the earlier period, there are no publications from Maghull at this stage – perhaps the staff were too busy teaching to write up their cases. A general article early in 1918 describes the hospital's method of treatment as 'principally psychotherapy', embracing 'suggestion, persuasion, therapeutic conversations, re-education and exercise of the functionally paralysed limbs. The physician, as it were, masters the patient, gains his confidence and analyses his troubles and morbid ideas, and sets his mind at rest' (White, 1918). It is clear from later accounts by Culpin and Hart that 'the revival of forgotten incidents, whether of actual warfare or of earlier life', and the 'reintegration' of these memories was now regarded as a crucial stage in treatment. The patient, wrote Hart,

must get used to his war memories, so that he may regard with comparative equanimity those past events whose recollection now fills him with anguish and terror. He must be persuaded to describe them fully to the physician, to face them squarely rather than shun them, and to discuss them with his comrades. (Hart, 1920)

There remained an emphasis on 'long, persuasive talks' (Brown, 1919a) and a belief that rational explanation of the processes producing a patient's condition would, if 'put into language easily comprehensible to men of mediocre intelligence and education' help him to overcome it (Hart, 1920).

It is noticeable, though, that the dramatic examples of abreaction quoted by Culpin took place after he had left Maghull and abandoned 'ordinary conversational methods' in favour of a technique of 'hypnoidal association' – 'direct[ing] the patient's thoughts along a definite path and in a definite manner' and even making sure that the 'correct style of description' (in the present tense) was used (Culpin, 1920, 1931).

'Then Jerry started putting them over and we had to retire' is an example of the useless style; I try to get something like this: 'I'm in a dug-out with

one of my mates, and a shell lands on the parapet outside; after a while we go out and see some of our chaps lying there wounded. . . .'

Like William Brown (and, in a later war, William Sargant and Roy Grinker), Culpin wanted to revive the emotion associated with wartime experience as much as the experience itself – something he was well equipped, by temperament and clinical experience, to do with ordinary soldiers. Nor was he inhibited by taboos about 'suggestion' (Brown *et al.*, 1920), whereas Hart's drier, more detached approach meant that, like Charles Myers, he 'discouraged the patient from giving rein to his emotions during treatment' (Myers, 1913). Myers, according to several who knew him, 'lacked the common touch' (Interviews: Hargreaves, Myers.).

Of the 4,000 cases admitted to Maghull, at least 80% (according to Rows, 1920b), were 'anxiety states' and many of those presenting as hysterical conversions turned out to be anxiety cases too. There are no reliable treatment statistics, let alone follow-up studies, but the local medical administrator talked of 'marvellous progress . . . Col Rows got good recoveries in practically every case' (White, 1921). The surviving hospital records say little about treatment, but give a good sense of the everyday practical problems – the difficulty of getting and keeping staff, the ceaseless struggle to maintain an edible diet under wartime conditions – in 1917, just when intellectual excitement at the hospital was at its height, 'staff and patients alike were reduced to a diet consisting mainly of bread, turnips and rice' (Leese, 1989) – and the appalling condition of patients' teeth. Wards could not be kept at normal levels of cleanliness 'due to the character and habits of patients', while in August 1918, the temporary huts were reported 'to be a disgrace being extremely dirty and ill-kempt. The night conveniences attached to each hut are most unclean with swarms of flies about. The men's clothes are hanging in the huts after washing. Much damage has been done to the walls.' The contrast to the golf-playing lifestyle at Craiglockhart is obvious (Rowlands, 1985).

The shortage of food led to a programme of agricultural labour at Moss Side Farm from the middle of 1917. Patients were allowed to eat some of the food produced and paid 2½ d per hour for their contribution (Rowlands, 1985). The importance of providing some sort of work in the 're-education' phase of treatment was by now generally recognised, and copied by other hospitals. (The neurologist Arthur Hurst persuaded the War Office to establish a 'shellshock' hospital at the agricultural college at Seale Hayne, on the edge of Dartmoor and his film *War Neuroses* shows idyllic scenes of ploughing and digging.)

A New Dawn?

The establishment of 'the first school of clinical psycho-pathology' in Britain was a landmark in psychiatric history, none the less remarkable for occurring on the windy Mersey under the auspices of the British Army, rather than in a Bloomsbury salon. It was understandable that in the heady climate of 1918, a Young Turk like the Jungian Maurice Nicol should exult that 'the orthodox medical reactionaries have been smashed and . . . psychology born' (Pogson, 1961).

And yet, if not a false dawn, it was certainly a hazy one. The 56 alumni

of Maghull went out into the world like disciples unto Judaea and worked honourably enough in Army hospitals and the new Ministry of Pensions clinics. But they never formed a coherent psychiatric school and many of their names remain obscure. There were several reasons for this. The regime at Maghull was pragmatic and diverse – the main lecturer, Bernard Hart, was ‘infuriatingly eclectic, a student of Janet, a friend of Jung, and admirer of Déjerine and Trotter’ (Pear, 1959). None of the staff quite had the spark of genius. But the study of ‘war neuroses’ was also entering a new and more complex phase in which ‘psychology’ alone was not enough.

On the face of it, the clinical literature of ‘shell-shock’ in 1917-18 is dominated by two diverse strands. There is, firstly, the psychotherapeutic approach, pioneered at Maghull and then elaborated by Rivers and McCurdy. At Craiglockhart, in the spring of 1917, Rivers took up Freud with fresh vigour (mainly because his *own* dreams seemed to bear out Freud’s scheme of the dream-work) and established with officer patients there a rapport he had never enjoyed with private soldiers at Maghull. The result was a series of brilliant articles which, by carefully narrowing down the problem to be discussed, ‘[made] the doctrine of repression intelligible’ (Ross, 1923) and showed how analytic methods could be used to treat officer patients with Anxiety Neuroses. Secondly, at the other end of the spectrum, some British neurologists were copying French techniques for directly treating symptoms of chronic hysterical conversion. Most notably, E.D. Adrian and Lewis Yealland claimed great success using ‘plain speaking backed up by a faradic current’ to ‘cure’ men whose paralyses, deformed gaits, or mutism had hitherto resisted months of treatment. But Yealand’s reputation was not helped by the immodest North American fervour with which he described his successes and by mid-1918, the ‘Miracle-Working’ mantle had passed to Arthur Hurst, who seemed to be showing, at Netley and then at Seale Hayne, that it was possible to eliminate hysterical symptoms by cleverly engineered suggestion alone.

Yet this is not the whole story. Rivers’s period at Craiglockhart was fairly brief; by the end of 1917 he had moved to London, to work mainly on the problems of flying. It gradually became clear that, for all the brilliance of his papers, his methods did not necessarily produce the same dramatic results, in other hands. Similarly, Hurst’s ‘quick, showy cures’ (Myers, 1940) began to look less impressive as relapses from Seale Hayne swelled the out-patient clinics (Culpin 1931, *Journal of Mental Science*, 1921). E.D. Adrian, for one, came to understand that a quick cure of hysterical symptoms was not enough, unless combined with some analysis of underlying anxieties; for him, ‘the miracle working methods soon palled’ (Adrian, 1967). On the other hand, as Bernard Hart acknowledged, ‘certain hysterical symptoms such as paralysis, functional gaits, mutism and so forth [could] be removed with ease and speed by suggestion or persuasion which would involve a lengthy and complicated procedure if they were treated solely by analysis’ (Hart, 1920).

If extended clinical experience tended to produce a more eclectic approach, it also led to greater pessimism as to outcome. By the end of 1917, a new clinical model began to creep into the literature – the man who had difficulty readjusting to civilian life because of repetitive war dreams, reacted with the ‘startle reflex’ to any sounds or stimuli reminiscent of battle, might be impotent, sometimes had quasi-epileptic fits, and often had a disturbed heart beat. ‘DAH’ – disturbed action of the heart – was becoming a commoner diagnosis.

These new variants of 'shell-shock' eventually produced yet another swing – away from 'psychology' towards a more physiological emphasis; a trend reinforced when it became apparent that the mere ending of the war did not bring an end to the 'neuroses of war'. This can be seen in Rivers's *Instinct & The Unconscious* (1920), which offers not the psychoanalytic interpretation towards which his 1917 articles had pointed, but a 'biological' account by which the pressures of war are seen to cause the nervous system to revert to earlier levels of functioning, i.e. to regress. Rivers was himself regressing back to his neurological past, as Hughlings Jackson's houseman and Henry Head's collaborator in the famous experiments of 1905-8. By 'continuing the vocabulary which [he] and Head had formulated' with its distinction between the protopathic and the epicritic, at a time when the original experiments were already coming under fire (from Trotter and others), he took an enormous risk (Miller, 1972, Pear, 1922).

Rivers's vocabulary was unique to him, but the idea of regression was also explored by McDougall, Read (1918), and Nicoll. Most British doctors, however, preferred to find the key to this cluster of symptoms in recent work on the effects of emotion on the endocrine system – of which W. B. Cannon's *Bodily Changes in Pain, Hunger, Fear & Rage* (1915) was only the most notable example.

How does emotional shock work? [asked F.W. Mott in December 1917] Very probably, the endocrine glands, especially the adrenal and the thyroid, are profoundly influenced by emotional shock, and [sic] the persistence in the subconscious mind of memories of experiences associated with terror or horror is revealed by the dreams of war experience (Mott, 1918).

Mott could be expected to seize hold of this idea, though, as this passage shows, he was at a loss to explain the connection between possible endocrine activity and war dreams. But *Functional Nerve Disorders*, edited by Hugh Crichton-Miller in 1920, shows 'psychologists' like Maurice Nicoll, William McDougall, George Riddoch, J.A. Hadfield, and J.F.E. Prideaux also trying to accommodate the endocrine factor – without great success. Similarly, when William Brown returned to Britain in early 1918 to take over at Craiglockhart, he found that he was unable to repeat with chronic patients there the almost miraculous results he had been achieving – with hypnosis and mild psychotherapy – on acute patients in France. Perhaps, he thought

the far-reaching extent of the bodily changes, involving cardio-muscular and glandular activity in addition to that of the voluntary and involuntary musculature, explains the intractableness of so many of these cases. (Brown, 1919a)

But it was the psychologists' patron, Ronald Rows, who came nearest to an answer, his background in neuropathology having equipped him to venture into the complex area of the effects of emotion on the nervous and endocrine systems. In a set of lectures in 1920, Rows went back to Sherrington and Head's work on nervous stimuli and Pavlov's writings on reflexes, trying to apply them to the 'war neuroses'. Did the experience of war, he asked, produce in soldiers conditioned reflexes which, once established, became reinforced again and again?

Rows produced vivid clinical examples which seemed to show that it could. He had one patient who 'passed into a state of terror on hearing the noise of a tin can falling'. It quickly emerged that, on this man's sector of the Western Front, the signal for an imminent gas attack was not the ringing of a bell but the beating of a tin can. Years later, the mere sound was enough to bring the terror back to him. A second man had been singing a hymn during a church service when he began to shake, his legs gave way, and he had to be carried out. It turned out that he had several days before seen a war-film in a cinema and 'at the moment the explosion of a shell was thrown on the screen the pianist in the orchestra at the picture-house had thumped on a low note of the piano'. The cinematic explosion had reminded him of the real explosion in France which had caused his original breakdown, and an indirect stimulus was enough to bring back the emotion. In these cases, Rows explained

Repetition of the memory of the incident . . . led to the laying down of a path which gradually became more and more facile to stimuli, perhaps of slight intensity but capable of awakening the memory; and when the memory was recalled the emotional state, which is specific in every instance, also reappeared. (Rows, 1920a)

This all has a modern ring to it. Here and there, Rows anticipates the much more elaborate analysis of chronic war neurotics which Abram Kardiner would eventually draw from his work in War Veterans clinics in the 1920s. This, in its turn, inspired work on Viet Nam veterans carried out by American 'biological' psychiatrists in the 1980s (Kolb, 1981).

But in England, Rows's work led nowhere. This was partly because attempts to translate it into therapeutics came up against a blank wall; Rows admitted that in one case

no obvious alteration of symptoms was produced by drugs such as atropin or pilocarpin, which are known to influence the sympathetic and autonomic systems, or by the administration of thyroid extract or bromides. No improvement was observable until a series of disturbing incidents in the patient's past life had been unravelled by psychic investigations and the mechanisms of mental processes had been explained to the patient. (Rows, 1921)

It was also due to Rows's isolated position, and his abrupt decline into obscurity and death.

The Decline of Rows

Rows left Maghull in 1919 to take up appointments at Ministry of Pensions hospitals in Richmond and Tooting, as well as a Consultancy to the Ministry. He also became in a modest way, a public figure. There was a C.B.E., an honorary degree at Manchester and a speaking tour of America; in 1924, he told a discussion on 'mental and industrial hygiene' organized at Wembley by the 'Peoples' League of Health' that 'the delinquent was made and not born'. He was, though, less active within the M-PA.

Then something went wrong. For in the spring of 1925, Rows returned to his old job as Pathologist to the County Mental Hospital in Manchester, where his friend David Orr had become Medical Superintendent. After a decade and a half of climbing ladders, he had evidently landed on a big snake. What had happened?

Scandal, professional exclusion, or ill-health are the obvious explanations. It is possible that Rows was blamed for two disasters which took place at the hospital at Tooting while he was in charge of the Neurological Section there. According to Dr Jonathan Miller (who heard the story from his father, Emanuel Miller) one patient, suffering from hysterical paralysis, was deliberately flung into the swimming pool and, far from recovering the use of his limbs and swimming, began to sink like a stone; he had to be hurriedly rescued from drowning by uniformed RAMC doctors. A second patient, after an apparently successful hypnotic abreaction, flung himself under a bus in Tooting High Street.

Such failures were however, probably quite common in a military hospital. The second possibility is that Rows was edged out when J.F.E. Prideaux became medical adviser at the Ministry of Pensions in 1922. But it is much more likely that his health collapsed. The sheer intensity and drama of the 'war neuroses' made them very wearying to treat – not least because under wartime conditions, the doctor lived with his patients rather than looking in on them once a week. Rivers could only take a year of it at Craiglockhart; Rows had had four. He was clearly burnt out when, in 1919, he had to defer a course of lectures at Edinburgh for a year.

The other pointer to Rows's ill-health was his role in the saga of the War History. Its wider historiographical importance justifies a quick digression.

Rows and the Medical Histories

The official British medical histories of the Great War describe some of the most dramatic and extraordinary episodes in medical history – Gallipoli, surgery on the Western Front, shell-shock – in some of the dullest and most forbidding prose ever to be bound together.

It was not meant to be like that. The Medical Research Committee had conceived the project on the grandest scale and made sure that wartime medical history was recorded in War Diaries, the storage of which took up by 1918 a large area of the British Museum (Herringham, 1919). But then the 'Geddes Axe' descended. Soon after the war, both money and will ran out abruptly, harsh deadlines were set, and the job was done in a hurry. A proposed series of popular medical histories by the novelist F.S. Brereton never got further than the first volume, ending in 1914. Brereton was lazy, but his real problem was in applying the jaunty heroics of *With Gun and Assegai to Ulundi* to the Somme and Passchendaele (Elliott-Fletcher correspondence, MRC;PRO – CAB 103/81).

The Official History handles 'shellshock' in so fragmentary and patchy a way that it might be thought that the Army, in its embarrassment, could scarcely bring itself to deal adequately with the subject. In fact, this was due more to confusion than conspiracy, the editors were aware of the inadequacies and did their best to correct them. None of them, however – T. R. Elliott, the Cambridge physiologist who represented the MRC in France; Sir William ('Tiger Mac') Macpherson,

Sloggett's deputy in the RAMC; and Sir Wilmot Herringham, one of the Army's consultants – fully understood the issues. All three had spent most of the war at Sloggett's headquarters near Boulogne.

The chapter on 'Neurasthenia and War Neuroses' should have been written by Charles Myers, who had set up and run Army psychiatry in France for two years (before being edged out by the neurologist Gordon Holmes), and then played (as deputy to Aldren Turner) an important co-ordinating role at the War Office in London. But when Myers refused to contribute, its writing was entrusted to William Johnson and Ronald Rows. Johnson had had nothing to do with 'shellshock' until 1917, when Gordon Holmes brought him in to run the treatment centres at Passchendaele. He wrote clumsily: his first draft, Herringham told Elliott in June 1920, had given him 'an infinity of trouble. I have made the best I can of it, but anything you can do to improve it will be worth doing' (Elliott papers, Wellcome).

Ronald Rows, commissioned to write about the treatment of 'shellshock' in Britain, had in the past shown himself a fluent and persuasive writer. But his first draft was disappointing – a mere 14 pages instead of the 'comprehensive article of about 50 pages' Elliott had hoped for; 'little more than a general essay that might have been written by anyone who was altogether outside the circle of those who were responsible for dealing with this great group of casualties', Elliott told MacPherson in July 1921. There was no discussion of different methods of treatment, and Elliott found it 'very disappointing that a specialised branch dealing with a certain group of casualties does not seem to have produced any clear body of evidence, statistical or otherwise, to which the writer could have referred'. After recommending that a 'tale about Field Punishment' be censored, Elliott concluded

It would be difficult to train a RAMC Officer in psychiatric medicine, in accordance with the suggestion on p 23, if no more evidence and information on this subject were available for the Corps than what is presented in this article as the outcome of work in a very great field of experience. (Elliott papers, Wellcome)

The editors faced a dilemma: should they get Rows to redraft his piece or rewrite it themselves? Who would talk to Rows? As a fellow 'UCH man', Elliott could 'probably smooth things over a bit as he must be told some home truths'. But Elliott was too busy; so Herringham alone – physician at Bart's, former vice-Chancellor of London University, and medical grandee – confronted Rows in the United University Club.

My heart rather went out to the little man [Herringham wrote afterwards to Elliott] I gave him an awful doing about what he had written and also about his omissions and he took it like a little lamb. (Elliott papers, Wellcome)

It makes a sad image: Rows – provincial pathologist, one-time agitator for mental health reform, risen to the heights of Lt Colonel – being effortlessly patronised in a London club by Sir Wilmot Herringham, K.C.M.G.: the 'little man' out of his depth and foundering badly. It is hard to imagine the Rows of 1914 'taking it like a lamb'.

The lack of statistics, which was not Rows's fault, was later remedied, but for all Elliott and Herringham's efforts, the original weaknesses remained. Perhaps it was a tall order for anyone to have written a coherent account of the shellshock saga in 1919, but the margin of Rows's failure suggests that his powers were beginning to fade. The inadequacy of his account has – despite the wealth of evidence to the War Office Committee on Shellshock in 1922, the vivid snapshot of British psychiatry which Salmon produced in 1917 (later reproduced in the *American history*), and Myers's later memoir – continued to distort the historical record.

Conclusion

Ronald Rows died suddenly in April 1925, aged 58. The only recorded tributes were from Hubert Bond and David Orr (Bond, 1925; Orr, 1925).

His last book, on epilepsy, was published posthumously a year later (Rows & Bond, 1926). Epilepsy was an obvious area of interest for anyone working in ex-service clinics in the 1920s, for the war had left a great deal of epilepsy and quasi-epileptoid symptoms in its wake (Kardiner, 1941). Rows argued that wartime experience showed that epilepsy was caused neither by heredity nor by gross organic lesions but by a 'disturbance of consciousness associated with an emotional state'. (Once again putting a 'psychological' argument from a neurophysiological point of view.) In trying to relate epilepsy to his earlier work on the ways in which external stimuli could trigger memories and emotions, Rows was certainly on to something, but unfortunately went on to assert that all epilepsy was psychogenic (in this sense), thus laying himself open to the obvious objection that infantile epilepsy was not caused by emotion. He also asserted that drugs had 'no legitimate place in the treatment of this or any other form of mental disorder' – at a time when the first anti-convulsant barbiturates were beginning to come into use. Despite a kind review from Aldren Turner, the book sank without trace.

Although Rows never returned there, Maghull was itself taken over by the Ministry of Pensions and remained a military hospital until 1933. It was then re-opened by the Board of Control as the Moss Side State Institution for mentally subnormal patients with severe behavioural problems. It is now due for demolition.

It would be wrong to make large claims for Rows; he was always in the second league of medicine, well behind major figures like Rivers and Head. Nor should he be overpromoted as the pioneer of today's work on Post-Traumatic Stress Disorder. But when and if we evolve towards a new synthesis about 'shell-shock' – one that does justice to its many facets – Rows has a small but honourable place in the pantheon. As David Orr put it, with only slight exaggeration

It was at Maghull that a progressive movement, which might have lain under a shadow in different circumstances, was brought to light. Colonel Rows . . . demonstrated conclusively . . . that the early treatment of insanity, although advocated by many of his predecessors, required nothing more than education, foresight, and courage to convert theory into practice, and so save many a drifting mental case from becoming a derelict. (Orr, 1925)

The traditional picture of Maghull as the seed-bed of British depth psychology and an island of hope and promise in wartime psychiatry, is correct – as far as it goes. Maghull was a marriage of pre-war stirrings and wartime opportunities, made possible by the presence, in fairly close proximity in the North-West of England, of a suitable building, an asylum professional (Rows), and a Cambridge man with access to the network and great promotional talents (Elliot Smith). The absence of these elements accounts for the comparative obscurity of Springfield, Maghull's sister hospital in London.

The Maghull group, far from being outsiders, were a powerful faction with important friends at court. Whether they had overt licence to ignore the Army's manpower needs is not clear, probably their social and scientific status shielded them to some extent. Amid the general confusion over 'shellshock', their success in returning men to civil life (if not to the front) made them the obvious people to train doctors in psychological medicine – though the fact that the War Office was simultaneously issuing English translations of Babinski, Roussy and Lepine's wartime writings shows that the Maghull line was never fully endorsed.

Maghull provided the launching-pad for the most important British theoretical account of 'shellshock', the brilliantly distilled articles which Rivers wrote in 1917-18. These introduced a diluted version of Freud to a wider medical public (Stone, 1985), but they were not the end of the story, the *terminus ad quem* of 'shellshock'. The old guard did not immediately roll over and concede; most patients continued to be treated along very traditional lines (Leese, 1989); even among 'psychologists' opinion continued to develop, just as the dominant type of patient evolved.

'Shellshock' had many fates, each emphasised in the literature at different stages of the war – hysterical conversions in 1914/15; the person with a pre-war problem brought to the surface (Maghull literature, 1916); the 'normal' man who had had enough (Rows/Rivers, 1917); and the chronic patient with disturbed dreams, problems of reflex, etc (1917/1918). Rivers's writings were based on his success at Craiglockhart with one type of patient – guilt-ridden officers like Sassoon. Because of their exceptional clarity, however, his articles had a considerable impact, ushering in a brief phase when analytic methods were in vogue and doctors solemnly analysed their own dreams (Ross, 1922). But this approach proved ill-suited to the chronic, or less intelligent patient. Disenchantment soon set in, a recognition that different patients required different approaches; by the end of the war the emphasis had, if anything, shifted away from analytic methods, back towards suggestion.

While, therefore, the war certainly forced on British doctors a 'recognition of the psychogenic factor', and convinced many of them of the value of psychotherapy (BMJ, 1920), what evolved after 1917 was an eclectic, common-sense psychotherapy, wary of Freudian excess and increasingly pessimistic as to outcome – a mood perhaps best expressed by J.F.E. Prideaux at a BMA meeting on psychotherapy in 1920.

Why . . . did they get failures? His experience showed that failures came under two classes. On the one hand there were cases (and these were in the majority amongst pensioners in the present time) in whom psychological treatment would never do any more than temporarily remove gross symptoms – they never had been and never would be able to face reality. They were of a high-grade type of mental deficiency, and

to them Janet's theories applied. On the other hand, there were cases who were suitable for and needed psycho-analysis; these cases owed their existence to the presence of infantile complexes. . . . Psychotherapy for the first type of case – the deficient type – could only lead to complete failure. (*BMJ*, 1920)

Prideaux's remarks show a noticeable hardening of tone, away from the sympathetic understanding shown to young officers in 1917 towards the hostile suspicion of the inter-war Ministry of Pensions. It is as if the educated and well-motivated patients have returned to civilian life leaving behind the weaker brethren.

Secondly, Prideaux comes close to acknowledging what was by then generally understood – some doctors were good at psychotherapy, and others were not. Although, 'shellshock' is usually discussed in terms of the different medical camps and approaches to treatment – Rivers's saintly patience versus Yealland's brutal electric shock treatment, etc – Rivers himself believed that the 'personality of the healer' mattered more than his method (Rivers, 1918). By the end of the war it was pretty clear that some doctors – Rivers, Brown, Eder, Ross, Culpin, Yealland, and Hurst – made effective therapists with the right type of patient and some – Myers, McDougall, Mott, Hart, and Holmes – did not.

There was, moreover, another element in the general pessimism, something which contemporaries stressed and modern writers have tended to ignore: compensation neurosis. 'The whole therapy was so vitiated by the pensions system' wrote T.A. Ross of his work between 1917 and 1921, 'that it was impossible to gauge the value of any form of treatment' (Ross, 1923). If a man got better he might lose his pension and with it his livelihood in hard times, and so, at a certain point, his recovery would falter and his symptoms return. Kardiner (1934a) reported similar problems, Myers (1940) commended the French decision not to award pensions to war neurotics. When British 'shellshock' doctors were asked in 1939 how the 'war neuroses' should be handled in a future war, nearly all recommended that there should be no pensions this time. Surprisingly in view of the tough line he had taken in the past – only Edward Mapother argued that such a policy would be unfair to men of previously sound character who were psychologically damaged by the war (Public Record Office PIN 15).

All of this means that when one turns to the 'big questions' – the war's impact on psychiatry in Britain, the effectiveness of different methods of treatment – it is difficult quite to share the tone of Whiggish optimism of some recent writers. Of course, Stone (1985) is right to stress that the experience of 'shellshock' transformed public attitudes to mental disorder and introduced a shaft of optimism, an expectation of cure, that was not there before. For instance, a doctor at Wakefield Asylum complained in 1920 that patients' relatives were now constantly demanding to know why they had not been given 'methods of treatment to which prominence has lately been given by the Press'; he was tired of explaining to them that 'suggestion, psycho-therapeutic conversations, hypnotism and psycho-analysis' would not help these cases (Robinson, 1921).

But within medicine, the war's effect is more debatable. Cultural historians now argue whether modernism in the arts was born of the alienation of war or was in full flower well before 1914. There is equally a case for saying that in some areas of psychiatry, the war delayed the coming of changes already in the offing. Lomax's *Experiences of an Asylum Doctor*, published in 1921, shows a system frozen

for the duration of hostilities. In the 1920s, the 'economy drives of the post-war period and the rapid evaporation of post-war idealism' (Hargreaves, 1964), plus a rearguard action by some in the profession, further delayed changes. Hayes Newington's gloomy predictions in 1914 proved correct: it was not until 1930 that the reforming agenda laid down by Rows and his colleagues on the eve of the war – voluntary treatment of patients, the removal of the stigma of 'pauper relief', the creation of out-patient clinics – finally became law.

Some of it, anyway: their bold dream that the whole culture of asylum medicine could be transformed was doomed never to be realised. The opening of the Maudsley Hospital in 1923 improved training considerably but Mapother was careful to keep the asylums at arm's length. Anecdotal evidence suggests that few high fliers chose to work in the mental hospitals, which remained the backwater of the profession (Sargant, 1967; Wishart interview).

Two important new institutions intended to offer 'early treatment' did come out of the war, but both the Cassel Hospital and the Tavistock Clinic embodied the wartime spirit of eclectic pragmatism. The Cassel was entrusted to T.A. Ross (1875-1941), a 'shellshock' doctor with a curious pedigree. For fifteen years before the war, as a GP on the Isle of Wight, he had treated neurotic patients by the Weir-Mitchell cure, achieving great success until he lost confidence in the technique. He had then adopted Déjerine and Dubois's simple form of psychotherapy – being, like many British doctors, repelled by the Freudians' emphasis on the sexual aetiology of neurosis. The war took him to Maghull – where, according to Pear (1959) he 'leapt at the new methods of treatment – and to Springfield. It also brought him 'face to face with the act of repression in the Freudian sense of the word . . . there seemed no escape from its overwhelming causal importance' (Ross, 1922). But, although Ross made a 'grudging admission' that 'Freud was clearly right about the importance of repression', he was also repelled by the way that 'the followers of Freud in this country persisted in trying to force the war neuroses into a sexual category in a way calculated to arouse the strongest opposition' (Ross, 1922).

Ross did make some use of analysis, but he soon lost faith in it. By 1922, he was arguing that

patients could be helped in a number of minor ways before this very serious business of Freudian analysis was embarked on; the light-hearted fashion in which it is employed makes one anxious for the whole future of psychotherapy.

Repression undoubtedly exists, but it is not the most important thing in the investigation of psycho-neurotic persons. A great deal that passes for repressed material never was repressed but was either merely out of the focus of attention, or put into the patient's mind by the analyst. The great stress laid upon the unconscious has tended to do harm in two directions: (1) In making people conscious of many images which they might be better without (2) in causing many things to be overlooked which might effect speedy cure. (Ross, 1922)

Ross's preferred to use a simple mixture of reassurance and mental 'readjustment'. In his hands they seemed to work and, despite the banality of his writings, his 'common sense' approach was much respected among more cautious doctors.

As for the Tavistock, its founder, Hugh Crichton-Miller, told a discussion on Mental Out-Patients Clinics in 1930 that he 'valued enormously people with different standpoints': his staff contained 'two perfectly good Freudians . . . good as far as Freudism can be good', two 'very prominent Adlerians and most of us have a strong penchant for the Adlerian school', two 'devout and intelligent Roman Catholics' for Catholic patients, and four married women who dealt with female patients. There was also 'always a certain number of people with a low intelligence quotient for whom magic is essential for a cure' (*Journal of Mental Science*, 1931).

Crichton-Miller's justification for this catholic approach was in the best traditions of Army medicine: it saved time. Even so, he added, sheer pressure of numbers made it difficult to offer anyone more than twelve hours of treatment. Such a situation wasn't perfect, but at least it kept some people out of mental hospitals; and it compared favourably to the psychotherapeutic department of a large hospital, where a friend or his, confronted by 80 patients to see in 2 ½ hours, could only offer 'a cheery manner, valerian and poſ. brom'.

The 'early treatment of mental disorders' had arrived – if not perhaps in the form Rows had dreamed of in 1914.

Acknowledgments

Dr John Rowlands generously provided a copy of his unpublished talk on Maghull, based on administrative records which he rescued; he also took me round the hospital. Dr Stephen MacKeith has, over several years and many meetings, instructed me in the complications of this subject. Dr Alan Costall and Mrs June von Patzelt kindly supplied material.

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Interviews- Professor Leslie Hearnshaw 1991, Dr Jonathan Miller 1993, Brigadier Edmund Myers 1991, Dr John Wishart, 1991.

Film- *War Neuroses* (1918)

Personal narratives of 'shellshocked' soldiers are beginning to emerge in the Imperial War Museum and Liddle collections. None, so far, refers to Maghull. Leese (1989) was unable to find a hospital magazine.

22 A Mental Hospital in 1929

DAVID PARFITT

The driver of the rickety, 12-seat bus belonging to the County Mental Hospital awaited me. When my two suitcases had been put in, I sat in the seat best placed for talking to the driver, who did not initiate conversation, though any remarks made to him were answered in a friendly fashion. Whilst there was no regular bus service, the hospital one helped to persuade nurses and others, especially the young women, to remain at their jobs there. It went to the nearest town most mornings at 10a.m., and met passengers near the railway station, returning to the hospital at 4p.m. Additional journeys were arranged from time to time to meet staff needs, as when I arrived, and all travel was free.

At the beginning of January 1929, the first inklings of dusk came early and liberal stretches of snow lay about, advising caution to drivers but causing no serious worry. At that time, though motor traffic was never excessive anywhere, it was less than average on the rather lonely road we were traversing, and the bustle of railway stations was soon forgotten. In the twilight, the bus's headlights were barely noticeable; later, I discovered that in pitch darkness, they were poor enough to demand slow speeds – not that this vehicle ever beat 30 mph. Even most cars then, while faster than vans, rarely exceeded 40 mph.

Having covered about four miles of road, in reasonable repair and just wide enough, given sensible speed, to provide room for three cars abreast, the bus turned to the right. Taking a last look ahead along the road, before we turned off, irregular outlines of several cottages could be seen and a larger, cosy structure. This was more brightly lit and displaying a hanging sign, backed by some bulky, belted trees – the local pub. The country road into which we turned was smaller in every way and seemed to lead nowhere. After less than a hundred yards, the conveyance turned abruptly left through an open pair of elaborate, fenestrated iron gates, set back and uninviting; these overshadowed the small lodge, on which was hung a large sign, 'PRIVATE'. The entry road, gently rising, soon curved to the right and after 50 yards or so, a well-built wall on the right allowed a brief view of an imposing set-back house, with a glass conservatory but without a garage. The newcomer made a first guess, which later turned out to be right, that he was looking at the residence of the Medical Superintendent.

The big garden abutted onto a two-floored, ugly wall, almost completely plain except for two smallish windows which were largely obscured by a row of trees, interspersed with bushes. He was to discover that the windows served to provide

daylight to steps leading to a corridor between the ground and first floors of the main male hospital. One could not escape noticing how well tended everything was and how pleasant the general design. The straight line of the Superintendent's garden wall and the block for male patients led to double doors, opening into a reception area. This served a considerable collection of rooms, which provided offices for senior staff. The straight line which continued with the female hospital, came lastly to a considerable vacant space, that I was to discover had been kept available for possible future building needs.

Arrival

At Reception, the central door led into the hall, and passed on to the larger half of the main building – the female block. Outside, the left side of the road leading to the entry doors was straight, but after the first 50 yards became a sloping bank, on top of which was an iron railing about four feet high and running to the far end. The road then divided into two; one part went straight on past the female block and a half-circle to the front of a two-floored building of better brick, well pointed, with larger windows. Although much smaller than the main building, its appearance was superior in every way. This was Leigh, the private wing of the hospital. The semi-circle of the road gently climbed left, as it formed a space for turning vehicles, and the space between the arms of the rising road was large enough to enclose two full-sized tennis courts, both well cared for and made trouble-free by high mesh-wire fencing. From the space in front of Leigh, a road extension ran a curved route to the house of the Deputy Medical Superintendent.

The reception room at Leigh was smaller than the main one, and was staffed by a polite, friendly woman, behind a long, narrow counter. There was an ordinary stand-up telephone on the counter, a large blotter suitably encased, ink, pens, a few containers for paper, and some leaflets in containers. The doctor's arrival had been telephoned. The driver, taciturn as ever, dumped the two suitcases and slipped away without being noticed.

There was a flat in Leigh for the Junior doctor, and when he arrived, a maid was waiting, young and attractive, whose resting face radiated pleasure, though whether she could stop smiling was difficult to tell. Her cheeks were rosy, though as the years passed, tangles of red lines would tend to replace the blush. The 'new boy' was in her charge. She went as if to carry the cases but, aware of the weight of books he carried, he hurried to relieve the young lady of the heavier of the two, and asked if she would lead him to his flat. After the plain, utilitarian bedroom, the shared bathroom and the large shared sitting and dining rooms at the general hospital in Cardiff, the new hospital flat seemed unusually elegant. The maid curtsied herself out and before long was back with tea, blackcurrant jam, and hot buttered toast. A newcomer, who was most likely to arrive at tea-time, would be informed that the evening meal was normally served in the main building, in the dining room of his immediate superior, but that first dinner was to be taken at Leigh, as a guest. His work began next day and the maid had given him a message from the Head Male Nurse that he, Mr East, would call for him in the Medical Office at 9.15 in the morning.

In my flat, lazily taking time, I arranged my possessions to my satisfaction and

settled down in a comfortable armchair for an hour's reading after dinner. When I was called by the same maid next morning, I was delighted to receive her pot of tea and a few *Petit Beurre* biscuits. She informed me that it was half past seven, and asked at what time would I like breakfast served? Starting this at about a quarter past eight, the porridge was found to be admirably fine and hot, with thick cream and caster sugar, followed by a tasty sliver of fish, an impressive piece of hot ham, a couple of fried eggs, and a round of fried bread. With Mr East in mind, the newcomer had to keep his eye on the clock, but being a fast eater, found time to enjoy a round of buttered toast and marmalade and finish off with a repeat of the good coffee.

The Medical Superintendent

Exactly on time, Mr East looked in at the Medical Office, and immediately we left together to see the Medical Superintendent. Even the confident Chief Male Nurse tapped the Superintendent's door deferentially, and was called in; he led the way, signalling the new doctor to follow. The Superintendent was in a well-furnished room, sitting at an imposing roll-top desk at an angle from which he could show full from the waist up, but edge sideways and almost disappear from view if he wished to do so.

His greeting smile lacked warmth and friendliness; duties were outlined without delay. The appointee would be in charge of the male side of the main hospital, covering for his senior on a roster which, he indulgently stated, they could arrange to their own convenience, remembering that one of the pair would be available and on call for every minute of the day. However, there was a rider – neither doctor left the hospital before 1 pm on any day. The remuneration would be £300 per annum, then rising by £50 per annum for two years. (In fact, at hospitals where it was more difficult to get a good choice of candidate, the salary for the first year started at £350, in either case with board and lodgings.) Church attendance when on duty was obligatory, morning or evening, and preferably both. In addition, the doctor on duty attended every function – weekly dances, occasional concerts, annual sports day, etc. If in reply to the questions asked on the application form, any hint had been given that an applicant could entertain in this way or that, this would also be the subject of enquiry on such occasions.

It was made explicit that if a private approach to the Medical Superintendent was required about anything, arrangements for this were to be made through Mr East. The newcomer was there to listen at this interview, and he gained a strong feeling that comments which voiced his own opinions were more likely than not to be unwelcome. The great respect the Medical Superintendent had for the Hospital's Matron was stressed for a second time, and the new doctor replied, 'I am quite clear about that Sir'. The Matron having been near sanctified, high commendation was given to two lesser 'Matrons' – they were not described as Deputies. If the Medical Superintendent could be compared to a Prime Minister, Mr East and these three Matrons would represent the Cabinet.

The new doctor said so little that the interview did not last very long; he nodded slightly in acquiescence a few times and presented himself as a careful listener, without any sign of worry. At last, he guessed the end was approaching when the Medical Superintendent said, 'Remember, that however junior you

may be, you are still an Officer and should be wary of being too friendly with rank and file staff; a very large proportion of them would take advantage of such a situation if the chance arose'. A minimal flick of the hand and Mr East was showing me out, saying 'No fixed time as yet, but I shall see you later'. The Medical Superintendent's door then closed, with Mr East inside the room.

The new doctor returned to the Medical Office, wondering what to do. An answer came quickly. Mr East's Deputy, who was awaiting him, informed him immediately but without haste that daily, either he or his deputy, officially ranking as the Office Charge Nurse, would accompany him on his ward round. He suggested that they started straight away; the doctor expressed his pleasure to do so, and they set out.

The Process of Adjustment

In spite of troubling aspects of the hospital, I settled in well. I was instructed about keys: no one should have the appropriate key for any purpose if it was possible to do without it. Elementary keys for junior staff were large and hung from a strong waist band, belt, or chain; ward keys were each large enough to be a weapon. With rising rank, there was access to an increasing number of places, and the keys became smaller, cut with finer steel.

I found it difficult, though, to enjoy my own appetite and the splendid food served to me in the face of the patients' usual diet – weak tea, lumpy porridge, bread and margarine, gelatinous jam, weak-looking corned beef, warm soup with chopped vegetables and small meat fragments, flavoured to create a delusion of strength and nourishment. A couple of beef sausages or a piece of seed cake were served twice a week, while occasional rock cakes provided chewing practice.

As time went on, I realised more and more that Mr East, the self-satisfied 'Jack-of-all-trades' acted as interpreter for the Medical Superintendent. It became clearer that the reminder that if any difficulties arose, the Head Male Nurse would put him right, meant that this person was the Superintendent's lieutenant. The doctor would save himself trouble if he understood that Mr East was a reliable informant who gathered knowledge for the Medical Superintendent and maintained an attitude of total deference for him.

One also learnt that it paid to double as the friend of everyone and the secret confidante of the Medical Superintendent, never failing to report to him things he would like to hear, including criticisms of all and sundry. He ran everything, and for each duty, received a small extra stipend, but though this was happily received, his greater pleasure was to know the power he wielded. Even the unpleasant Matrons were careful to keep in his good books, though this was not too difficult, since mostly, they thought as he did. One of these queened it at Leigh, with many fewer patients than occupied the main hospital and a higher ratio of staff to patients. Having to deal with superior and more demanding relatives, she was ranked higher than her counterpart in the main hospital, where patients' relatives were very small fry.

Amongst other things, the Superintendent was the leader of the fire brigade – on the spot and tackling the job before the local brigade arrived; he and his chosen few were also the ones who liaised with the St John's Ambulance Brigade. A local entertainments organisation put on concerts, musical evenings,

and visits of professional singers, pianists, violinists, etc. On these occasions, Mr East, with instructions to his Deputy, drew from staff and patients the number which would almost fill the hospital's big hall. The Superintendent's ability to lay on a capacious hall for the event increased still further his standing in the community. Not least, he was the director and conductor of the band, which gave indoor performances about every six weeks during the Winter and carefully chosen musical route marches during the better months.

Beginners were not expected to be familiar with psychiatry – in fact, the subject was not mentioned at my initial interview with the Superintendent. Assiduous attention to and care of any patient who was sick from whatever cause was highly important, but even while the instruction to give this was being imparted, mental disturbance of any kind received no mention. The assumption was that attention aimed at improving the body would give any help necessary to the mind. In conversation later, the senior assistant doctor sometimes touched on subjects of some psychiatric interest and it was from him that enlightenment concerning the importance of the D.P.M. (Diploma of Psychological Medicine) was gained; if the examination was passed, it involved an extra rise in salary of £50 a year.

My immediate senior, with whom I spent almost two hours over the evening meal four or five nights a week, filled me in about the surprising call I had received to this hospital appointment. It appeared that a genuinely dour Scot had been appointed, who was capable and outspoken. It took only a little time for him to be affronted by the odious Superintendent, his false smiles and sneers, so that this doctor asked to see the Committee. He was persuaded by the Superintendent to take whatever full pay and expenses were owing to him, and leave. At that time, I was searching for a job and filling in with locums, and so by calling me in and not mentioning the change to the Committee, the Superintendent's bacon had been saved.

It increased the supremacy of the Superintendent if he did not hobnob with his medical staff, though they were sometimes honoured by being invited to activities suited to his needs – badminton, tennis, bowls, bridge – but no more. On one or two evenings a week, I completed the Superintendent's four for badminton in the big hall, where the floor was kept clearly marked out. My senior and the laboratory assistant completed the party, for which racquets and shuttlecocks were plentiful; mediocre badminton is easier to play than squash or fives at the same level. I was also one of the better soccer players, so that I became captain of the hospital team, and we won a much-prized local cup.

The nursing staff were housed in groups of rooms according to rank, promotions usually involved transfer to improved accommodation. The hospital could be seen as a habitation, perhaps a fortress, that could exist on its own provided that arrangements were in place for a water supply. Behind the main hospital there was a very large, high-standing circular water tower, an engineering centre, a laundry, and large boilers for the heating system. If the buildings had not been kept warm, there would have been no staff.

In a sovereign position, there was the Visiting Committee. This was composed of 12-20 responsible person of good standing, who felt that their position in life demanded some service to the community. Three or four of them in fact worked hard and conscientiously, while most of the others ventured opinions and did their ward rounds, giving and receiving approval as they saw fit. The Clerk to the Committee was usually the head of a leading local firm of solicitors.

Incidents with Some Patients

I was quickly introduced to hospital customs, and learnt how the institution functioned. Doing the ward rounds on one occasion, when Mr East was off for the day, the Charge Nurse of a ward said, 'I'd like you to have a chat with one of my patients, if you would'. I nodded assent and he brought across a smiling patient, approaching 50 years of age, remarking that this man would tell me his story. The man interrupted his work with a floor-polishing 'bumper'; this had a long, strong broom handle with a rectangular base, one foot by one foot and a half, and about three or four inches deep, with a kind of carpet cover. It was heavy and the floor-boards shone; I was always expecting that someone would slip on them. The patient then ceased smiling, his benign, parsonic appearance took on a solemnity befitting a burial service, and he fixed me with eyes like the ancient mariner, beginning to speak with increasing intensity. 'It was a message from Heaven, we were at the battle of Mons and I was the first to see the angels there; they spoke in strange silence yet the message was clear – 'Hold on and victory will be yours'. They disappeared, but came again and the news spread.' He spoke distinctly, with intensity but then more quietly, his eyes never wavering as he neared me, lest a word be lost. 'The silent message stayed with me and in 1919, I took up Holy Orders. I was later sent to Africa and became the first Bishop of Pretoria and afterwards Bishop of Birmingham.' The deepening silence was hypnotic until suddenly, he let out an explosive scream, which sent me springing back in alarm and he swung away convulsed with laughter. The Charge Nurse was delighted with the show.

Another 'animal trick' occurred in a neighbouring ward where the patients were a little more unpredictable. There, I had already developed a passing acquaintance with a sharp-tongued, offensive manic-depressive. In those days, this meant a patient who had had at least one attack of both depression and mania. At this particular time, he was manic and in a good enough mood to repay the subtle coaching of the Charge Nurse: like a dog or monkey, he had mastered his trick. There were other patients in the ward who were similar, but lacking his skill. A few of them had a history of attacks on others before admission, but I never saw this man make even the mildest physical attack on anyone during the year I spent in the hospital. He was a dab hand, though, at conveying imminent danger to others, and when I was in the ward, the Charge Nurse neutralised any possibility of danger by his strategic placement.

On one day, though this picture seemed largely unchanged, the Charge Nurse was relaxed, and something was afoot. Several patients formed a surrounding audience, and I was informed that the patient had caused a watch to vanish and return. In the circumstances, it would have been difficult for me to avoid appealing for a repeat, and with some condescension, he agreed. The watch reappeared and after a variety of strange hand and arm movements, one of them a casual sweep under the table, disappeared again. Before I could comment on his sleight of hand, the successful patient was jeeringly happy and remarked, 'Mr Evans,' – the Charge Nurse – 'had his 15 year-old nephew in as a visitor the other day, I didn't deceive him and you should know why. When I quietly swept a hand under the table to show that all was clear there, the lad hadn't the kind of mind that goes down, deep down, loses the fresh air where the trick is taking place. It's the clean mind that counts; not a mind that drops into the dirt.' He maintained

his sneer while saying so little – an expert indeed. I congratulated him without confessing that I was a little irritated, and I sensed the general feeling in the audience that the doctor had been taken down a peg.

In another ward, on the ground floor, a silent, expressionless, and apparently totally disinterested little man was leaning against the wall, near the exit door. I was informed later that he gained mild pleasure by noting the identity of everyone who passed him, and that he was a consummate actor in his own opinion. He was aged something over 40, but had never earned a living in his life. His father had died about 20 years before and his widowed mother then lived in genteel poverty with him. He took walks with his mother, occasionally read books, and gradually became more and more deluded; occasionally, he shook her violently. Eventually, he was sent to the hospital, apparently indifferent to what had happened, but got on well with his mother when she visited and was discharged back to her care. A second admission followed a little over a year later, and this was repeated after a second discharge, his mother then being in failing health. In hospital, apart from his solitary nature, he appeared unworried, and his present stay seemed likely to become permanent. Mild frustrations, sometimes nothing definable, caused him to deliver stage addresses, and he had let it be known that they were Shakespearean. He spoke well, with a good stage voice, and was able to enunciate each word clearly at surprising speed, though it was often not possible to relate his declamations to any actual situation. The Charge Nurse not only encouraged him covertly in this, but became able to tell when a mildly provocative remark or a few expressions of interest would start him off.

On one particular day, the Charge Nurse had only to ask politely that the patient move a little and make it easier for the doctor, to start him off with a declaration which certainly sounded Shakespearean and was listened to with undisguised approbation. It was all the more striking because of his customary silence, immobility, and state of almost totally living within himself. Here was a fury of resentment not matched by his words, either in their enunciation or accuracy, although I never doubted that the Shakespearean flavour derived from reality. His first outburst was more or less, as follows:

Sir, think not I would hang on your favours
vain glory joined of this world, I hate you.
You will fall like Lucifer, never to rise again.
You would force down a falling man
In all the miseries you have forced on me the martyr.

The Dispensary

To the far right-hand corner of Reception (the first call nearly every day), as one entered, was the Dispensary or Pharmacy. This consisted of two rooms, the front one being entered by a door that was usually open. It looked smaller than the space available because the walls were lined, wherever possible, by a series of cupboards, the contents of which were identified by labels in slots. There were also two parallel, open racks of shelves, each well stacked. Large Winchester bottles were perhaps the commonest items, but potent drugs were in smaller bottles on narrower shelves, while a variety of fixed boxes contained powders and

scoops. A few syringes, with needles attached, were kept in a sterile container with labels; if not used, they were re-sterilised after a few days, so as to be ready for an intramuscular injection, if any patient was disturbed enough to need one.

As one entered, the most right-hand drawer was of very deep length - equal to the considerable number of other shelves of substance containers. This was at a little below eye-height. Inside the Dispensary, it was labelled 'NIGHT DRAUGHTS', as it was outside, in the narrow corridor which ran there. Every day, this particular drawer was checked by the Pharmacist, so that each night - when it was left locked from the inside - it was accessible from the outside. Each doctor had a key for it, as did the Senior Night Charge Nurse and Night Sister, while a few other senior people had one locked away for special occasions.

The contents were two-ounce bottles of paraldehyde and an equal number of identical bottles, since this dose was completed by adding a further ounce of water. Though a high proportion of patients had paraldehyde regularly on going to bed, the extra bottles in this cupboard could be used at any time if indicated. The extra dose was given if one was in any doubt - a procedure which reduced extra calls back to the wards at night, and made things easier for everyone. Paraldehyde caused very little trouble if drunk quickly, though the taste was revolting and the smell nauseating. In practice, delays in giving out the doses caused irritation and shaking, so that when it came, it was wolfed down and the patient usually settled off to sleep even before a drug effect had been achieved. It is fortunate that the sense of smell for a particular odour wanes fairly quickly and in the case of paraldehyde, it is not long before it is not detectable by the patient. However, when one walked into a ward, especially a male one, where sometimes the prescription approached the universal, the pervading smell throughout was unmistakable and most unpleasant.

The Medical Routine

Whatever else the patients were, the majority were clearly harmless; their regular examinations were organised by senior nurses. Most were passive, either refusing or unable to carry on sensible conversation, remaining inert, or making inappropriate movements or irrelevant remarks. Apart from spontaneous, minor restlessness, many could be strangely immovable for hours at a time. Some, without showing improvement, gradually became less suspicious and dropped into the easiest routines of hospital life; they acquired the habit of moving to the dining table at mealtimes, and lost their early resistance to daily washing and weekly bathing, though nail and hair cutting were more slowly accepted, probably because they were less frequent. Some of the staff had given up attempts to develop a friendly relationship but mostly, they were cheerful and encouraging towards their charges and could hardly avoid carrying out with increasing skill daily procedures which could not be avoided, taking a little longer with the less common jobs.

Sometimes, the careful search by the doctor for physical diseases revealed something unusual, and arranging a visit by a specialist, although not encouraged, could be done. Tube feeding was resorted to without delay when necessary, especially if it seemed obvious that weight was being lost. The feeding gags were made so that the upper and lower shafts were strongly made and with good

purchase; when the thumb and finger rings were pressed towards each other, they separated the two flat pieces. These were thin, but thick enough never to break, and lay side by side, making it as easy as possible to find a place of entry where they could be slid into the mouth. After this, the ratchet of the feeding gag and steady pressure with thumb and finger made it possible to force the jaws apart. A funnel was attached to the open end of the thick rubber catheter, which had a couple of holes towards the end; then, with the forefinger of one hand working in conjunction with the inserting hand, it was not difficult to pass the wet catheter into the stomach. Any doubt was removed by lowering the funnel below the level of the patient's stomach and aiming it at the centre of an enamel bucket on the floor.

The feeds were fluid, the first one consisting of ten ounces of milk and glucose, but thereafter they were gradually increased, made richer with cream, the only extravagance; they were given twice a day, with up to 30 ounces of fluid in each feed, if things went smoothly. Such a regimen seemed always effective; the tube-feeds were ordinary, accepted procedures comparable to, say, the enemas administered by the senior nursing staff. No harm seemed apparent from them. Some patients took food willingly after the first day or two, while occasionally others rapidly learned to go to the appropriate chair, while the large bib was put on, and then drop the lower jaw to open the mouth widely. They might continue like this over many months, or even years.

Glancing through the case notes at examination times, one learned that many chronic patients, under very little pressure, were persuaded either to carry out certain ward duties or to help in the gangs working on the farm, the laundry, the kitchen, or any place of need in the hospital. The more important staff members gave to the more able and conscientious patients the distinction of working for them, mostly paying them a few shillings each week, but otherwise, they received no more than acceptance, smiles, and some words of praise.

With patience, observation, and symptomatic medicines, plus encouragement to take on responsibilities, schizophrenic patients usually became fit for discharge in anything from 9 to 18 months. The patient would then disappear, but in a year or two often returned with the same symptoms that had caused the original admission. This might be the final admission, but sometimes there were three or four before everyone – the hospital staff and even more the patient's relatives – grew tired of the repeated failures. Then, without complaint from the patient, residence there became permanent. There were patients with a variety of depressive states, one group being the 'manic-depressive', but followed over a period of years, some of these became indistinguishable from chronic schizophrenics.

Visits of the Commissioners

Once a year, specialised civil servants – the Commissioners in Lunacy – arrived at the nearest hotel in time for dinner. There were two, one qualified in Law, the other in Medicine, and one senior to the other, bringing with them notes of patients to whom interviews were to be granted, together with the details of complaints, events, accidents, illnesses, and requests which were better investigated on the spot. These Commissioners arrived at the hospital by

taxi, without prior warning as they thought – a routine procedure occurring at roughly the same time each year. In fact, the news of their arrival was always telephoned to the hospital, as soon as they came the evening before, and the long practiced drill got quietly under way, taken very seriously. The side was never let down and no one laughed.

On these occasions, the speed and efficiency shown were admirable. Every nurse, male and female, who could be made available, was called in, even if they were off-duty, as well as a few other people who could clean and polish or had skills which might be useful, helping to make apparent to the Commissioners the good level of staffing. For patients especially, but for staff as well, the best clothes were put on, washing, shaving, and tidiness in general were given attention, all rubbish disposed of, Bibles placed here and there. It was checked that there was no shortage of acceptable literature – daily papers were increased in number and placed at strategic points, old copies of *The Illustrated London News*, *The Tatler*, and other well-known periodicals were spread about in reasonable numbers, toilets were carefully cleaned, toilet paper properly available in adequate quantities, hand and bath towels changed if necessary, toothbrushes with names attached were put out, a few urgently needed haircuts were given, a nail scan picked out those requiring immediate attention, one of the better meals was set in preparation for midday and fresh lemonade with water and a syphon of soda water graced the ward dining tables, even caster sugar was put out – unrecognised by most patients. Their meal would consist of a tasty, thin soup with bread rolls, preceding something like lamb with genuine mint sauce, delicious vegetables, and then a creamy rice pudding. There would be sensible portions of everything, certainly not too little but wisely, never too much. This served the double purpose of suggesting affordable quantities, while avoiding any risk of patients vomiting after an excessive meal, ravenously eaten.

Nor were the Commissioners forgotten at lunchtime. The Superintendent, who had seen them quickly after their arrival, caught up with them again then and shared a superior sherry with them, before they were left alone to explore their own ideas. Care was taken to serve them the best of the best, including such special offerings as the thickest cream that could be poured from the jug – if not used on the rice pudding, it was often added to the superior black coffee. The Superintendent would have a third and final chat when the Commissioners settled down to a fresh pot of tea and some light accessories at tea-time, while the more legible writer of the two wrote out the joint report. Most Superintendents took careful notes of financial suggestions – of what could be foregone, or of cheaper substitutes for expensive schemes which were, in their view, hard to justify, since the Hospital Committee had the responsibility of keeping down costs to ratepayers. There were still asylums which regularly kept the weekly cost per patient per week below one pound, though very few things became cheaper at this time, more showing slight increases as the 1930s began. Progressive ideas were common enough, but difficult to realise after the lessons and debts following the Great War. Some Superintendents used the Visiting Commissioners as an aid to make their own Hospital Committees appreciate fully how desirable their own suggestions were. However, the one pound limit remained a powerful deterrent: bursting through that barrier might initiate a flood of further expense.

Mental hospitals were increasing in size everywhere; their numbers of patients

went up every year, at a time when unemployment and falling standards of living were increasing the frequency of human failures. The commanding voice of the Board of Control had made a decision that any new building envisaged, planned, or even discussed, had to be a new admission hospital for both sexes; this was a sound idea, but offering little as an answer to the existing overcrowding. In many cases, adding extra beds in the better wards or, when possible, enlarging these, could have created good provision, but the Board of Control was deaf to all such appeals. The Law underwrote the power of the Board, which remained adamant on this question, and far too often, next to nothing was added. Declining structures were patched up, and some new bits were built to advantage, but insufficiently to do much for the worsening overcrowding.

In one hospital, though, there had been an ingenious solution to the ward overcrowding problem. A high brick wall was built out over the field which abutted on a ward, built several years before and carrying facilities reasonable for an admission ward; the wall came off an opening made in the corridor of the Admission Ward, opposite the entrance to the bathrooms, WCs, and handbasins. It had room for 24 beds in a straight line, and looked extraordinarily long. A brick floor about 12 ft. wide ran its length, and was built up to be level with the corridor floor; above it, an unbreakable glass roof, with a forward slope, was a foot or more wider. The raised strip of brick floor had two ramps, sloping down to the field. At the far end of the wall, a small extra wall ran from the new one to the back of another ward, and completed an extensive space given special blessing and much hard work by the Head Gardener; it was made into something wonderful by the presence of a magnificent oak tree. Whenever weather made it possible, the beds were carefully manipulated down the ramps and spread more or less evenly around the tree, in which position, under the spreading branches, they could be pushed away from or back nearer to the tree trunk, according to the intensity of the sun.

There was no heating, but the beds were well protected from above, though rain might blow in if the wind was in the wrong direction. They had adjustable backs and fitted, green waterproof canvas covers, with longish sides. I never saw one of these rain-protectors loose or slipping, nor the head-end suffering from the rain. Hot water bottles were replenished as necessary, but were a considerable addition to the work of the night nurses, who were dressed up warmly during the long period of work in the fresh air. Every member of staff who worked there learned the miracle of 24 hours, day and night, of life in fresh air: one old lady of 80, who appeared to be dying, was offering herself for ward work after a fortnight of this regime. This addition almost doubled the size of the Admission Ward.

Hutton (1960 described a similar arrangement at the Larbert mental hospital in Scotland, in about 1912. The Superintendent, Dr G.M. (later Sir George) Robertson 'was an advocate, indeed a pioneer, of sanatorium conditions in the acute stages of mental illness, and many of the patients were kept in bed on wide verandas summer and winter.' Later, she followed him to the Royal Edinburgh Hospital, where 'wide verandas, where selected cases could be nursed under sanatorium conditions, had recently been added'.

Since it was uncommon for the medical staff of a mental hospital to decide whether a patient was admitted or not, the local authority Relieving Officer had the chief responsibility here and as a result, the more unquestionably psychotic a prospective patient was, the more readily was transfer from the community or

other form of care arranged, the most urgent being the admission of psychotic patients who threatened or had actually shown violence. However, with the passing of the Mental Treatment Act in 1930, patients seen in clinics or at private consultations began to be admitted as voluntary patients, i.e. they signed application forms asking to be admitted, and could discharge themselves if they wished to do so. It was not long before it came clear that better results were achieved with such patients than with the severely disturbed mentally sick, who had been given priority because they were a danger to the community. Over the 1930s, there was a steady growth of patients admitted on a voluntary basis; some decades later, hospitals became less and less willing to take psychotics, particularly the deluded and dangerous, which was an unexpected reversal of the original priority.

Postscript

Two years later, in 1931, I was attending weekly teaching sessions for sick children, supervised by Professor Parsons. During their lecture-discussions, a couple of his Registrars would sometimes make merry gibes to the attendant students. They invited laughs at the extraordinary fact that official teaching visits of people called psychiatrists were now made monthly, to expound on mental diseases - whatever these were. I was experiencing two contradictory worlds, which did not communicate with each other in any meaningful way.

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III. People

23 'A Worthy Feeling Gentleman': Samuel Hitch At Gloucester Asylum, 1828–1847¹

LEONARD D. SMITH

Samuel Hitch (1800 – 1881) is best known for his leading role in the formation of the Association of Medical Officers of Hospitals for the Insane, the precursor of the Royal Medical Psychological Association and the Royal College of Psychiatrists.² His success in initially bringing together a group of his fellow asylum superintendents and physicians was achieved partly through the high regard in which both he and his work at the Gloucester asylum were held. His contribution to the development of institutional psychiatric practice in Britain has been somewhat overshadowed by those of contemporaries such as John Conolly and Robert Gardiner Hill. Influential as their innovations were, they occurred in the context of a critical stage in the evolution of the public asylum system, which fostered varied attempts to confront the spectre of chronicity and to preserve curative principles. Other practitioners, among whom Samuel Hitch was one of the more prominent, were affected by the same pressures and contributed to the flow of ideas, discourse, and debate which characterised asylum practice in the later 1830s and 1840s.

Samuel Hitch was appointed as the second superintendent of the Gloucestershire county lunatic asylum in April 1828, following the departure of his predecessor George Poynder to take over the superintendence of the new Kent county asylum. He was a local man, born at Stonehouse in Gloucestershire on April 1st, 1800, the son of a clothier. He was educated at Oxford, and subsequently attended medical schools in France and Italy as well as in England. He qualified initially as a surgeon, but ultimately went on to attain his physician's qualification (and Royal College licence) in 1840. J.C. Bucknill later recalled him as 'an able, busy, bustling intelligent man', small in stature, with red hair. According to family legend, he was not blessed with good looks, but considered that he could make up for this with charm. A former colleague and friend, Dr T.H. Huxley, who succeeded Hitch as medical superintendent at Gloucester and who then became the long-serving superintendent of the Kent county asylum, considered him 'one of the cleverest men in England'.³

The Gloucester Asylum

Proposals were agreed to establish a lunatic asylum in Gloucester, funded by

public subscription, as early as 1793; the prime mover was the prison reformer Sir George Onesephorous Paul. Funds continued to accumulate steadily, but were not sufficient to enable the project to proceed. Paul was instrumental in bringing about the parliamentary Select Committee on the State of Criminal & Pauper Lunatics in 1807, and was the main witness before it. The County Asylums Act (Wynn's Act) that followed in 1808 adopted the committee's proposal to promote not only the provision of asylums for paupers, but also arrangements for county magistrates to join with voluntary subscribers to erect an asylum which provided in addition for privately and charitably funded patients. This had the great advantage of relieving the county ratepayers of the full burden of capital expenditure. Of the early group of county asylums built under the provisions of the Act, several adopted this option of the joint asylum. In Gloucestershire agreement was reached in 1812, with the county putting up $\frac{1}{20}$ of the money, the city of Gloucester $\frac{1}{20}$, and the voluntary subscribers $\frac{9}{20}$. After several years of delay, due to factors such as the deaths first of the architect and then of the surveyor, objections to the financial arrangements by Sir G.O. Paul, and general prevarication, the Gloucestershire county asylum finally opened on the outskirts of the city in July 1823.⁴

From its design, the Gloucester asylum was an imposing structure, with a crescent-shaped frontage reminiscent of the architecture of the nearby spa towns of Bath and Cheltenham. It was later described as having more the appearance of an aristocrat's mansion than of an asylum; with its extensive grounds, it commanded views over much of the surrounding countryside. The magistrates and subscribers had endeavoured to ensure that the building was an ornament to the city and county, and a symbol of their munificence and wealth. William Stark, the original architect, noted for his work on the Glasgow asylum, had adhered firmly to the principles of 'classification', a key element of which was the complete separation of patients by social class. To meet this requirement, the officers and the wealthier private (or 'first class') patients were to be housed in some style in the crescent, while the charitable ('second class') and pauper ('third class') were placed in the rear wings. The pauper cells were built back to back, opening into narrow galleries, thus restricting light and ventilation. The committee responsible for the early planning acknowledged in 1813 that this would render them 'a little gloomy', but comforted themselves with the knowledge that:

But as we thereby gain a great addition to the number of rooms, and as the patients are to be in them only during the night, this circumstance cannot be of much moment.

These arrangements were later to become the subject of considerable criticism, however.⁵

Gloucester's first superintendent, George Poynder, previously an assistant at Bethlem Hospital, was recruited on the basis of recommendations including that of Lord Robert Seymour, one of the leading lunacy reformers. The Matron, Mrs Chambers, also came with references from Bethlem. Poynder took advice from the superintendents of county asylums that had already been established in regard to both administrative matters and models of practice. John Garrett of the Stafford asylum, which had opened in 1818, assisted Poynder in the

initial planning and equipping of the new asylum, so ensuring that Gloucester also had plenty of iron window guards, iron gates, and restraint instruments. William Ellis of the West Riding asylum at Wakefield, also opened in 1818, gave Poynder detailed advice on his principles and arrangements for the employment of patients. These proved particularly influential, with Gloucester following the Wakefield lead in the promotion of the therapeutic value of employment.⁶

Lack of funds meant that not all the building was ready when it opened in 1823. The intended capacity was for 24 first class patients, 36 second class or charity patients, and 60 paupers, but most of the accommodation for the charity patients remained uncompleted until early 1825. By this time there was a severe financial crisis, as minimal numbers of private patients had been attracted, evidently due to the perceived undesirability of incarceration in a public asylum alongside people from the lower social orders. The charitable plan to provide for members of the impecunious non-pauper working and trading classes was thwarted by a lack of sufficient funds to enable the subscription fund to operate. The finances were only relieved by the growing demand for the accommodation of pauper patients. By 1828, with the pauper sections full to overflowing, and demand increasing, the expedient was adopted of admitting paupers into accommodation intended for second class patients. By the end of the decade, though, the original intentions were nearer fulfilment. The subscription fund had finally begun to offer some assistance, and the public stigma had lessened sufficiently to encourage a gradually rising number of lucrative private patients. At the end of December 1830, the asylum contained 76 paupers, 4 charity patients, and 21 private patients, still short of its full capacity.⁷

There continued to be problems associated with Gloucester's constitution as an asylum for all social classes. With paupers being housed in accommodation intended for second class patients, some of the latter had to be accommodated with the wealthy private patients. The presence of disturbed paupers in accommodation designed for people of higher standing led to complaints of the damage that had been caused to furniture and fittings. The voluntary subscribers, though still not having funds adequate to increase the scale of their operations, were increasingly disgruntled at what they viewed as the subsidisation of paupers by the profits from private patients, which they considered should have gone to augment the subscription fund. As a result, compensation had to be paid by the county to the subscribers, and eventually, in 1840, a new settlement was negotiated.⁸

During the 1830s and 1840s, the Gloucester asylum was subjected to similar pressures as the other county asylums. The number of patients grew from 75 at the end of 1825 to 273 at the end of 1845. The steady accumulation of chronic patients, deemed incurable, together with spiralling referrals for the admission of pauper lunatics, had combined to create a growing pressure on accommodation. The county magistrates were reluctant to undertake further substantial capital expenditure, which resulted in the need to increase capacity by various creative means. A disastrous fire in 1832 had at least produced a significant amount of insurance money to provide for some extensions. The occupation by paupers of rooms intended for charitable patients was not a permanent solution, as the numbers of the latter grew. Overcrowding had become acute by the summer of 1842, with 272 patients housed in accommodation designed for 194. The exigencies of the situation were met by various schemes to adapt, convert, extend,

and vary the use of existing parts of the building, until funds were finally made available in the 1840s for major extensions.⁹

Despite its various difficulties, the Gloucester asylum gained and retained a reputation as one of the best managed and most successful of the early county asylums. In 1835, J.C. Prichard observed in his *Treatise on Insanity* that Gloucester had achieved an unusually high proportion of recoveries. Caleb Crowther, the flamboyant ex-physician to the Wakefield asylum, similarly commented on this in 1838. Figures compiled by the Metropolitan Commissioners in Lunacy, for their influential report in 1844, confirmed Gloucester's lead in the achievement of recoveries. The Belgian Dr Crommelinck, conducting a survey of British asylums for his government, had described Gloucester in 1842 as being 'one of the most agreeable, best kept and most important establishments in England', and this appears to have become the general consensus of opinion. Crommelinck and others gave a good deal of the credit for the asylum's achievements to the ideas, drive, and energy of its superintendent, Samuel Hitch.¹⁰

The Moral Manner

Terminology has become rather problematic to historians attempting to consider the care and treatment of mentally disordered people in the first half of the nineteenth century. Not only have the terms 'moral treatment', 'moral management', and sometimes 'non-restraint' developed a confusing interchangeability, but the meanings of each have not been interpreted consistently. The fault seems to lie with those historians of psychiatry, who have interpreted the methods adopted by the Tukes at the York Retreat as being the embodiment of 'moral treatment'. The term, however, preceded the work of the Retreat, and to most contemporary writers and alienists it described not a specific and systematic approach to care, but rather the psychological aspects of treatment as distinct from the medical and physical aspects. Thus, it was common practice for medical and lay practitioners alike to describe both their medical and their moral treatment and to pursue them in tandem. 'Moral management' perhaps more aptly describes an overall regime which incorporates moral treatment principles, though it has also sometimes been used to refer to psychological treatment on an individual basis. 'Non-restraint' came later, in the 1830s, and was an extension of the humane approach which the Tukes and others had promoted; this emphasised the importance of more permissive management techniques as distinct from medical treatment. However, the retrospective merging of 'moral treatment' and 'non-restraint' has led to some over-simplification and blurring of an evolutionary process.¹¹

Some historians have argued that the early group of county lunatic asylums were set up under the direct influence of the 'moral treatment' of the Retreat. In reality, though, there were a range of influences. The Select Committee of 1807 and the Act that followed in 1808 envisaged asylums run on similar lines to the public subscription institutions of the later eighteenth century, like St Luke's or those at Manchester and York. The shortcomings of York and of Bethlem Hospital, highlighted by the reports of the Select Committee of 1815, did not result in any fundamental change in the model, but rather a greater vigilance to detect and prevent abuses. Samuel Tuke's *Description of the Retreat* of 1813, well

received as it was, did not carry any immediate significant influence on the way in which public asylums were managed. Only at the West Riding county asylum, partly designed by Tuke himself, were some of the principles of the Retreat consciously put into effect, though duly modified to meet the constraints of a large asylum solely for pauper lunatics. Most of its contemporaries took guidance and information from the existing public asylums and lunatic hospitals; in several cases, as at Gloucester, they recruited their first house surgeon or director from Bethlehem. These appointments reflected a traditional approach, which continued in most of the county asylums until the 1830s and beyond.¹²

Samuel Hitch had clearly been influenced by the principles of moral management, though he did not initially promote a particular management system. When he commenced his duties at Gloucester, he continued to work within the framework that his predecessor George Poynder had established. The rules and regulations of the asylum, laid down prior to its opening and similar to those of other asylums, prescribed fairly clearly the role and duties of the post of house surgeon and superintendent. His responsibilities also included those of apothecary and of secretary. The emphasis was predominantly managerial: he was to 'superintend the general economy' of the house, had to be constantly resident, and could not act professionally outside the asylum. There were a range of administrative duties, which included the entry of details of admissions and discharges, the keeping of accounts and inventories, the pursuit of arrears of payments, the preparation of returns for the Quarter Sessions, and the purchase of equipment. The maintenance of standards was a key aspect; for instance, the superintendent had to regularly inspect the wards and bedding. Crucially, he was responsible for the supervision of staff and for ensuring their proper treatment of the patients.¹³

The direct therapeutic responsibilities were not inconsiderable, although here the superintendent's role was clearly subordinate to that of the house physician. He was required to enter admission details in a book, for the information of the physician, and to keep casebooks in which the physician would prescribe the treatment. He was expected to visit the patients at least twice daily, and to report his findings to the physician. He was to purchase and administer medicines under the direction of the physician, though he could prescribe or take other rapid action in an emergency. The nature of the hierarchical relationship was underlined by the requirement that he should never be absent when the physician was to attend. Onerous and extensive as his general duties were, an ambitious superintendent was always likely to find these distinctions and the limitations to his authority irksome. In some asylums they were a source of open conflict, though this does not appear to have been the case at Gloucester. Hitch's response was rather to utilise his available powers to the maximum, and ultimately to qualify as a physician himself.¹⁴

Hitch set out from the beginning to impose his presence on the asylum and its management. He proved a diligent and energetic superintendent, prepared to confront staff, parish officers, and magistrates in pursuit of what he considered the interests of the house and its patients. Within a few months of his appointment in 1828, for example, he sharply rebuked the parish overseers of Dursley for failure to send the proper admission papers with a pauper patient, and threatened to summarily discharge him. He had the fortuitous opportunity to enhance his reputation as a decisive man of action in April 1832, when fire

broke out at the asylum early one morning. On receipt of the alarm he 'instantly mounted into the roof'. Finding the rafters on fire, he summoned all available help, and sent a messenger to the city for assistance, which resulted in the arrival of the 14th Dragoons, and fire engines from Gloucester and Cheltenham. He personally organised the evacuation of all the patients to safety. Although the damage proved extensive, particularly to the central part of the building occupied by the first class patients, the only injuries were to some helpers who fell off a ladder.¹⁵

Hitch sought to foster and maintain a regime that was efficient and well ordered, and which provided conditions conducive to the promotion of the patients' general well-being and prospects of recovery. To pursue this goal he was prepared to be outspoken, as in October 1834, when he protested strongly to the visiting justices and subscribers about the failure to provide new facilities for the 'noisy' male patients. In consequence, the ward remained:

in the same bad state it was – *cold – unventilated – & scarcely fit for human habitation* – particularly in *very cold* or *very hot* weather – & that it is essentially necessary for want of other proper accommodations that something should be done.

His strictures eventually brought a result, though it took until the following April for the Quarter Sessions to agree to sanction the money. Hitch was again calling for action in October 1835, over the perennial asylum grievance of inadequate water supplies. The supply had failed completely, and he complained bitterly that 'he is oblig'd to haul water by the hogshead from a considerable distance & under very disagreeable circumstances' in order to provide for all the asylum's purposes. The visiting magistrates found it difficult to ignore his demands.¹⁶

Where the interests of the first class patients were involved, Hitch took a particular interest. He appears to have generally regarded them as offering greater prospects of successful treatment, given the right conditions, and accorded them special privileges. This led to a dispute with the House Committee in May 1830, after a pauper patient absconded from a work party outside the boundary walls and caused a disturbance at the house of a prominent visiting magistrate. The committee clamped down on all outside activity, including Hitch's practice of allowing first class patients to take country walks, either with himself or a keeper. They advised him that he had not been granted any authority for such practices and that he would be held responsible for any inconvenience occurring to the public. Hitch responded immediately by stopping the walks, which brought a written protest to the committee from a patient, one Captain Capel, who spoke of the grievance experienced by the first class patients which would prevent his remaining here. The committee relented to the extent that they advised Hitch that he was not precluded from taking convalescent private patients for walks, but that he had to ensure that those selected would not be likely to annoy the public in any way. It was probably not coincidental that Captain Capel escaped through a window in September, and that Hitch was despatched to London to fetch him back.¹⁷

Hitch was keen to ensure that the facilities for private patients were of a sufficient standard to sustain their custom. In May 1832, he argued for improved sanitary facilities for the private patients in the crescent. The water closets were

situated inconveniently adjoining their sleeping and sitting rooms, 'frequently giving rise to unpleasant smells'; he wanted them moved to the 'extremities' of the crescent. We also called for the removal and replacement of the wash house, the ill effects of which were felt by the 'Female Opulent Patients' in their airing court and day room:

the smell from the washing of the foul Linen is so overpowering that patients are frequently compell'd to quit the Apartment.

Most of these improvements were carried out with the aid of the insurance claim resulting from the fire. By the time of Dr Crommelinck's visit in 1841, the facilities for private patients were as comfortable as in the best private asylums.¹⁸

Notwithstanding his sometimes forthright approach, Hitch achieved the respect and co-operation of the Committee of Visitors. By the mid-1830s, with the growing number of patients, the range of responsibilities attached to the superintendent's post had become increasingly difficult to fulfil satisfactorily. In 1836, he was able to persuade the committee to appoint a resident house steward to assist with the administrative aspects, and in 1838 he was further relieved by the appointment of a clerk. By early 1839, he was becoming increasingly dissatisfied and frustrated with the services of the elderly matron, and he wrote at length about it to the committee chairman, Rev. Charles Crawley. Crawley was sympathetic, expressing the view that:

a person cannot be kept in such a situation until they absolutely drop off, and that at a certain age dismission though not implying blame, is to be anticipated.

Hitch did not have to wait too long for the desired result. The matron's proneness to exceed her responsibilities and to act independently in dismissing and hiring staff led to a reprimand in July 1839, which proved to be the prelude to her resignation in September. This provided the opportunity, doubtless anticipated, for Hitch's wife Anne to be appointed matron, thus further consolidating his influence over the running of the asylum.¹⁹

Freed from some of his administrative burdens by the appointment of additional officers, Hitch could concentrate more on the therapeutic and supervisory aspects of asylum management. He was well aware of the importance of the role of the keepers or attendants in translating the ideals of care and cure into direct practice with patients. High standards of conduct and discipline among the staff were maintained. In 1836, it was resolved that there should be no recruitment of married staff, and that any who subsequently married would be dismissed. Undesirable social activities also brought retribution. Fraternisation between male and female keepers in the female pauper wing led to the dismissal of four in August 1832, 'as a fit Example to the other Servants'. In April 1834, Hitch dismissed two long-serving male keepers for drunk and disorderly conduct, one of them having surreptitiously obtained the key to the beer cellar. He also secured the agreement of the House Committee to removing the right of keepers to go out on alternate nights. He considered that the present regulation:

had many Evils connected with it – it open's facilities for peculation & drunkenness, which the Superintendent has reason to believe has lately been practiced.

At the same time, he proposed a revised wage structure whereby keepers started on a lower wage, which was then raised by annual increments. A further multiple dismissal of four nurses occurred in July 1839, for various offences which included entertaining workmen.²⁰

Disciplinary action for maltreatment of patients, where detected, was swift and severe. The Gloucester asylum rules were more detailed than most. As well as laying down the specific duties of the male and female keepers, they supplemented the normal injunctions against violence toward patients with expectations of appropriate interpersonal communication:

9. No Keeper shall at any time attempt to deceive or to terrify a patient; nor to irritate the patient by mockery, by mimicry, or by wanton allusions to anything ludicrous in the present appearance or ridiculous in the past conduct of the patient.

10. No Keeper shall indulge or express vindictive feelings, but, considering the patients as utterly unable to restrain themselves, the Keepers must forgive all petulance and sarcasms, and treat with equal tenderness those who give the most, and those who give the least trouble.

While there must have been difficulty in ensuring that such requirements as these were adhered to, Hitch did exact prompt punishment for physical abuses. In March 1841, he instantly dismissed a nurse who had struck a patient, and a year later discharged another at a moment's notice for the same offence. In November 1844, two male attendants were sacked for assaulting a patient, partly on the evidence of other patients 'considered sufficiently sane to be depended upon'. Rather more colourful was the dismissal in August 1841 of George Cook, who had been a keeper almost since the asylum opened, for having while drunk taken a male patient 'of the worst class in almost a state of nudity' into the laundry where female patients were working. Whether these instances of disciplinary action served to enforce standards of behaviour, or whether they were signs of more widespread abuses can only be conjectured.²¹

Hitch's therapeutic approach steadily evolved during his tenure of office. He adhered strongly to the position that most mental disorders had a physical basis. He wrote in 1844 that he always looked upon the insane as:

under the influence of physical disease, it is true, but occasionally shewing itself and becoming susceptible of amelioration or of cure.

It was therefore necessary to begin the process of treatment by seeking the organic lesion and removing or neutralising it where possible. Despite this concentration on organic aspects, he was not an advocate of the more drastic antiphlogistic remedies then employed widely in the treatment of insanity. According to the somewhat sceptical J.C. Prichard, writing about the Gloucester asylum:

the use of the lancet, leeches, cupping-glasses, blisters, drastic purgatives, the practice of shaving the head, are totally proscribed.

In his avoidance of these treatments, Hitch was clearly in accord with the asylum's long-serving physician, Dr Hardwick Shute. Prichard was far from convinced of the correctness of their approach, but had grudgingly to acknowledge Gloucester's high success rate. Where Hitch did go along with Prichard was in the recognition of 'moral insanity' as a separate category of mental disorder. He submitted several case examples which Prichard cited in his *Treatise*. They demonstrate examples of disruptive and anti-social behaviour, though from Hitch's descriptions these appear in several cases to have been symptomatic of a wider disorder, rather than a primary disorder.²²

Since soon after its inception, the therapeutic regime at Gloucester had been focussed largely around promoting the employment and occupation of the patients. Hitch's predecessor, George Poynder, had adopted much of the model developed by William Ellis at Wakefield: a new section of the asylum's rules was added to deal with employment arrangements. Hitch developed and refined the system, so that Gloucester's employment arrangements were probably second only to Wakefield.

Pauper patients were employed both inside the house on a range of domestic tasks and clothing manufacture, and outside in the gardens and extensive grounds, as well as in construction and maintenance work on the building.²³

In early 1833, a large piece of adjoining land was purchased for £1,200 in order to extend outdoor employment opportunities, and more land was acquired during 1837. In 1838, Hitch arranged that female patients as well as males would be employed outside, rather than be restricted solely to the laundry and other domestic tasks. Incentives to work, or rather disincentives to idleness, were introduced in early 1839, when those who were not prepared to work had the meat content of their diet reduced and their dinner-time beer allowance removed. In several instances, the purpose of patients' work was not solely therapeutic, but designed also to economise on the use of outside labour, such as in building walls or in digging trenches for the gas pipes. Labour arrangements became increasingly regulated and sophisticated, and by 1842 a resident tailor and resident shoemaker had been appointed to work with male patients. These arrangements did not, of course, extend to the first class patients, though there was an instance in 1840 when a male private patient was taken on trial as the paid asylum accountant. The private patients were offered the alternative of a range of indoor and outdoor recreations and amusements, including musical evenings and country walks, according to their states of bodily and mental health.²⁴

As he continued in post and his authority grew, Hitch's personality came increasingly to dominate the asylum and its management. He gained the widespread respect and often gratitude of his patients and their relatives. Thomas Truebody, writing to Hitch in 1839 on behalf of his brother, spoke of 'your Exclent treatment as practiced in your invaluable Institution'. The husband of Mrs Bosley, a discharged patient from Worcester, wrote in 1840 on behalf of his wife to thank Hitch for the kind attention he had shown which 'will long be gratefully remembered'. The ailing husband of a depressed patient from Wales, Jane Roberts, who was agitating for her discharge, wrote in 1843 to try to console his wife. He could not agree to have her 'relaced from under the judicious care of your favorit Dr Hitch'. He was sure that Hitch would keep her no longer than necessary, for 'I always found him to act has a real Gentleman in

every sense of the term'. Mary Rich, recently discharged home to Mangotsfield in May 1841, wrote to Hitch to tell him of how she was settling in, describing herself as 'your very thankful inmate'. Similar sentiments were repeated by a number of other former patients. Hitch was generally assiduous in writing to relatives to advise them as to the progress or otherwise of patients, and numerous surviving letters attest to their appreciation of his trouble. Much more than a desire for ingratiation seems to have produced their various compliments and tributes. The wife of James McGregor, a pauper transferred the previous year from a Bristol workhouse, expressed her thanks in December 1841 for Hitch's 'verry humane reply' to her last enquiry. She felt convinced that her husband was being taken care of by 'a worthy feeling gentleman'.²⁵

Innovation and Controversy

In December 1840, Samuel Hitch was enrolled as a licentiate of the Royal College of Physicians. It had been apparent for some time that he felt restricted by the limitations of his role and that he sought more control over the medical aspects of treatment, as distinct from the 'moral' and 'management' aspects. The House Committee recorded that the institution had been 'honoured' by the circumstance of his additional qualification. With his personal prestige enhanced, and his wife installed as matron, Hitch's position at the head of the asylum was greatly strengthened. This provided him with the opportunity to proceed with the implementation of new practices within the asylum, as well as to play a part in the wider interchange and dissemination of ideas on the most effective and therapeutic means of managing patients within a large asylum.²⁶

Hitch had not been one of the early adherents of the abolition of mechanical restraint which, as in the other county asylums, had been an integral part of Gloucester's *modus operandi* from its inception. However, he had made some tentative attempts to reduce the amount employed. An official visitor reported in July 1836 that he had seen only '5 females under restraint and 2 males'. Nevertheless, three months later, Hitch was arranging for the purchase of 14 restraint chairs of the type used at the Middlesex asylum (Hanwell). He began to consider the issue seriously in the light of the public debate which developed following the publication in 1839 of Robert Gardiner Hill's book on his abolition of restraint at the Lincoln asylum, and John Conolly's adoption of non-restraint at the large Hanwell asylum. Hitch visited Hanwell in early April 1840, just as the fierce debate between protagonists and antagonists in the columns of *The Lancet* was entering its early stages. He was deeply impressed with what was being achieved, and reported back immediately to the Committee of Visitors:

Mr Hitch states that having been to the Hanwell Asylum he found that no personal restraint is there used upon any patient which is stated to conduce greatly to the cure – & that this is effected by having more day-rooms & more keepers in proportion than at this Asylum.

Although the committee were not in a position to provide further day rooms, they agreed immediately to supply the additional male and female keeper which

Hitch had told them would be enough to contribute greatly toward achieving this purpose.²⁷

Whilst Hitch proceeded quickly to reduce restraint at Gloucester, he adopted a cautious approach and would not declare himself an abolitionist. The annual report for 1840 claimed that the avoidance of personal restraint, so far as may be considered compatible with security had always been the rule and the practice in the institution. It acknowledged that the evidence from several large asylums showed that restraint could be avoided to a much greater extent than had hitherto been thought possible. However, Hitch dissented from the proposition that restraint was ‘under all circumstances, prejudicial’, considering that the ‘experiment’ had not yet been fully tried out in a large asylum. He also argued that the frequent alternative of seclusion of refractory patients was really another form of restraint. This reluctance to go further in support of non-restraint brought Hitch briefly into the controversy raging in *The Lancet*, when Serjeant Adams (‘A Looker On’), one of the prominent Hanwell visiting magistrates, criticised the limitations of the 1840 report.²⁸

Hitch continued steadily to pursue complete abolition, though without proclaiming it. During 1841, the Committee of Visitors sanctioned ‘in fact, but not in a universal regulation’ the total disuse of restraint. Rev. Charles Crawley, the chairman, was suitably impressed with the results. Visiting in December, he found:

everything connected with the asylum in the most perfect state of order. Though restraint of every kind is wholly abolished, not a sound of disturbance or noise is heard even in cases of patients who were formerly most refractory and violent.

A general improvement in behaviour and cleanliness was being observed, among all classes of patients. The previously critical Serjeant Adams in May 1842 expressed his ‘unqualified gratification’ that Hitch had become a convert, acknowledging the wisdom of the ‘judicious mixture of enterprise and caution’ with which he had implemented non-restraint in ‘his admirably regulated asylum’. Robert Gardiner Hill wrote of his pleasure at Gloucester’s accession to the non-restraint camp. The asylum Visitors joined in the praise, speaking in November of the ‘unbounded credit’ which was due to the system ‘so humanely and judiciously adopted by Dr Hitch’. They were now prepared to make the policy explicit.²⁹

Non-restraint at Gloucester was not without its problems, though these did not compare with those experienced at the Lincoln asylum, which led to Gardiner Hill’s resignation in March 1840. The tranquillity and order that followed in the wake of liberalisation could not be expected to last indefinitely, and the need to control disturbed or violent patients presented growing difficulties. Hitch, though an opponent of seclusion, was forced to persuade the house committee to approve the fitting up two padded rooms ‘for the worst cases of refractory patients’ in October 1841. Three months later a further two were installed for the second class (charity) patients. More were added subsequently, and arrangements were made for under-floor heating, so that patients could be kept in them without clothes. The Visitors were commenting fairly regularly on the excited state of patients, particularly the female paupers. Hitch on several

occasions attributed this to the state of the weather, and in September 1844 more specifically to the 'electric state of the atmosphere'. Disorderly behaviour continued to prove problematic for those asylums which had dispensed with the sanctions of restraint.³⁰

The furtherance of non-restraint formed only one aspect, albeit an important one, of Hitch's drive in the 1840s to implement a thorough-going regime of moral management. Another aspect was to ensure that patients were as widely occupied and stimulated as was feasible, according to their capabilities and social background. Opportunities for employment, indoor and outdoor, were widened. The cultivation of fruit and vegetables was developed, with patients given the responsibility to look after the crops, and rewarded with the opportunity to share the produce. Growing numbers were trusted to work, with limited supervision, in the fields outside the asylum walls. The appointment of a resident tailor and shoemaker in 1842 was followed by that of a carpenter and a bricklayer in 1843. Their arrival made possible the erection of a new lodge, a dead-house, and a brewhouse, all using patient labour. Visitors to the asylum were duly impressed with the range of work being carried out.³¹

The recreational activities, geared mainly toward the first and second class patients, were also extended. There were outdoor walks, and excursions to the country and local events. In the house, they were offered similar fare to that of the best private asylums, with games like chess and billiards, and music making, as well as weekly dancing evenings, accompanied by refreshments, when the normal asylum rules of separation of the sexes were waived. Hitch became increasingly aware of the possible therapeutic benefits of these events. Crommelinck described a dance he was invited to attend, which lasted from seven until eleven, with a break at nine for supper, punch, and the loyal toast:

This same evening, Dr Hitch succeeded in making dance a single woman whom melancholy had reduced to not uttering a word for six months. The dance that evening dissipated her mutism, and Dr Hitch considered it of great hopes.

He widened the opportunities for musical stimulation, by the institution of regular singing events, when some of the poorer patients were permitted the opportunity to join in with the more privileged.³²

One of Hitch's particular innovations was to introduce training for young students, who would spend time in the asylum and contribute to its daily running. As early as November 1839, he sought information from the Gloucester Infirmary as to their arrangements for taking medical students. In June 1841, a scheme was initiated for up to two 'Assistants' of each sex, who would spend twelve months in the asylum. They would receive no pay, but would have free board and lodging. The male assistants, or students, were to have completed their medical education, and would pay £100 per annum for their training. They were expected to deal with some cases, and write them up in the case books. The females, whose duties would be determined by the superintendent, were to be 'well mannered persons of the middle classes, or if possible above it'. The assistants of both sexes were to spend much of their time with the patients. The thrift-minded Visitors anticipated that these appointments would provide them with the opportunity to dispense with the services of one keeper of each sex.³³

Although initially there was some difficulty in recruitment, the scheme was in operation by early 1842. The assistants' role was essentially one of befriending and of stimulation of the patients:

They reside constantly with the patients – head their tables – join in their excursions – promote their amusements – arrange their difficulties – and act in all things as their friends and advisers.

The visitors were particularly gratified that the students would enable the 'objectionable' services of keepers, who belonged to the class of 'menial attendants', to be restricted, keeping them to their 'proper position' as servants upon those in ill-health. After a few months the experiment was considered a success, and partly credited with the improved behaviour of the patients. Hitch actively fostered the assistants' involvement in the social life of the asylum. He established an arrangement whereby they assembled daily for meals and amusement with the first-class patients of both sexes and with the members of his family, all in 'one domestic party'. The scheme was undoubtedly geared toward meeting the needs primarily of the private patients.³⁴

Hitch was deliberately trying to promote an advanced policy of liberalisation in the asylum. At his behest, the visiting magistrates declared that the institution should be regarded as an 'hospital for the cure of the insane' as well as an asylum. Female staff were employed to work with male patients on some wards. However, the most significant aspects of the policy were in the degree of freedom and latitude he was prepared to grant to selected patients. He wrote that the degree of confidence he placed in his patients was 'a point of treatment, on which I flatter myself that I leave all the other doctors far behind me'. He claimed that about a fifth of them were placed under no restrictions whatever. On Sundays, groups were allowed to attend services in various churches around the locality and the city, mostly unaccompanied by staff. They were left to 'supervise one another'. Hitch maintained that their consciousness of the privilege granted 'always has the power to make them exercise sufficient control on their actions'. In individual cases, convalescent patients would be allowed out for walks with their relatives. Selection for these privileges inevitably meant that they were granted to those not likely to abuse them and whose public demeanour would reflect well on the asylum. This meant that it was the first class patient who, according to his state of mind, as Dr Crommelinck put it:

goes out on foot, mounts a horse, rides in a carriage, goes hunting or fishing, or travels through the town as the country.

The trusted pauper patients' privileges, on the other hand, did not generally extend beyond being allowed to work outside the asylum walls.³⁵

A number of other measures were introduced with a clearly rehabilitative aim. A fund was set up in 1836, similar to those at the Wakefield and Hanwell asylums, to provide financial assistance to 'indigent' patients after discharge, in order to enable them to re-establish themselves in the community. A visiting French doctor in 1847 reported on an arrangement not unlike a half-way house, whereby a group of 14 patients who worked outdoors were living semi-independently in a dormitory, with adjoining kitchen and dining area, and a door opening into the gardens outside the asylum walls. They had a good deal of freedom

to cater for themselves and to order their own domestic routine. They could apparently come and go as they chose, subject only to the discretion of the gardener by whom they were supervised. Unfortunately, little else is known about this experiment.³⁶

Arrangements for periods of trial leave were implemented by Hitch, whereby people who were not fully ready for discharge could spend time with their relatives. Judging from correspondence received in October 1844 from a Mrs Rutter, whose son had been allowed home for a few days, Hitch was prepared to take a significant level of risk in this policy. While her son had enjoyed outings to the Clifton Observatory and the zoo, he had later become very agitated, shouting and gesturing, and demonstrated 'fear and terror' because of torment by evil spirits. Mrs Rutter sought Hitch's guidance on how best to manage him before his return to the asylum. This liberal policy was altogether too much for the Metropolitan Commissioners in Lunacy, who openly reprimanded Hitch for letting patients go out without a formal discharge and then receiving them back without fresh certification. They were particularly disconcerted that:

ten or twelve Pauper Lunatics appear to have ingress and egress from the Asylum at all times, at their own discretion.

The Commissioners objected strongly to the practice, which they considered contrary to law, but there is little to indicate whether or not it was altered.³⁷

It was Samuel Hitch's desire to disseminate new ideas and promote good practice that had led him to circulate his fellow asylum doctors in 1841, and to become the driving force in the establishment of Association of Medical Officers of Asylums and Hospitals for the Insane (AMOAH), the first professional association of those working in the mental health field. His concerns increasingly took him outside Gloucester. He developed a particular interest in the problems of Welsh speaking inmates of English asylums; in September 1842, he joined the campaign for an asylum in the Principality, with a powerful letter to *The Times*. Hitch became increasingly sought after for advice and guidance by people engaged in setting up new county asylums, such as those for Derbyshire and Somerset, as well as North Wales. In September 1844, he was appointed by the Poor Law Commission as a temporary Assistant Commissioner, 'upon account of his familiarity with the treatment of the insane', in order to conduct an enquiry into the treatment of pauper lunatics in the Leicester and Birmingham workhouses, which had been criticised strongly by the Metropolitan Commissioners in Lunacy. In May 1845 he was invited, on the advice of Lord Ashley (later the Earl of Shaftesbury), to join John Conolly at the Northampton asylum in the selection of a new superintendent to replace Thomas Prichard. Evidently, Hitch's professional reputation had been enhanced along with his growing prominence.³⁸

His prestigious secondment as an Assistant Poor Law Commissioner in the autumn of 1844 provided Hitch with the opportunity to present some of his ideas to the Commission. As might be expected, he criticised in strong terms various aspects of the care which was being provided to lunatics within the two workhouses, both of which contained 'insane wards'. In particular, he commented on the poor, overcrowded accommodation, the lack of washing or bathing facilities, the deficient staffing arrangements, the absence of classification, and of opportunities for employment or other occupation. He argued

that the insane pauper 'is entitled to a consideration beyond his poverty', and that asylum places should therefore be available for all, however unlikely their prospects of improvement. This solution, he suggested, would be more simple and more humane, as well as more economical, 'because it would necessarily diminish the number of the permanently incurable'. He called also for a national system of visiting to be established by the Poor Law Commission, whereby all the insane poor, whether in asylums, workhouses, with relatives, or boarded out, would be periodically monitored to ensure proper care and treatment.³⁹

Hitch's conception of the asylum as a means of achieving moral reform was particularly evident in the reports on the two workhouses. He considered their lack of supervision and structure to be highly detrimental to the lunatic inmates. In the Birmingham workhouse, for example, the sexes were not fully separated, which raised the possibility that the 'worst and most indecent feelings' would be aroused and that the 'grossest immorality' might take place. The consequence was 'to demoralize where the mind is already too debased and where elevation is so indispensably required'. The asylum, on the other hand, with its order and discipline, could change behaviour for the better. He described one of the Birmingham inmates, Sarah Field, as being a 'most woeful example of blasphemous conversation obscenity and ill conduct' to the young females around her; she was 'scattering the seeds of evil' among them. Hitch wanted her removed to an asylum, in order to remove the contagion. Another inmate, Charles Ford, was:

a perfect nuisance to both sexes from his frequent foul and blasphemous vociferations and he ought not to be allowed to annoy and disgust so many persons as he hourly does.

If he were in a 'well regulated Lunatic Asylum', he could be taught to moderate his language. Mary Brown, in the Leicester workhouse, was, according to Hitch, a victim of moral insanity. She was dangerous to others, and her refusal to work set an example that was 'injurious & destructive to the discipline of the House', whilst her impertinence to the Matron created a continual disturbance. Although what might be achieved was limited, he had little doubt about what needed to be done:

She will not be cured, it is most probable – but she would be improv'd by the discipline in the Asylum, here I would advise her to be sent immediately.

This seems a particularly significant position that Hitch was adopting, for he was admitting the curative limitations of the asylum, but ascribing to it a wider role as a vehicle to bring socially disruptive behaviour under control.⁴⁰

By the early spring of 1845, Hitch had decided that it was time to reduce his responsibilities. He had been unwell after completing his work for the Poor Law Commission, and ill-health was the reason given for his resignation as superintendent, which was to take effect in the midsummer. Presumably, the volume of work and the energy with which he pursued his innovations, had taken their toll. There had also been some frustrations associated with his

inability to bring about necessary improvements in the state of the asylum, particularly for the pauper patients. Crommelinck recorded that Hitch had protested continually about the state of the pauper accommodation, with its back-to-back, gloomy, airless cells and narrow corridors. The problems were compounded by the asylum's growing overcrowding, which led Mrs Hitch to lodge a written protest to the House Committee in January 1845, while her husband was sick in London. She complained that in the female pauper wing, 113 occupants were in accommodation suitable for no more than 85, which resulted in the mingling of violent with quiet patients, and which had led to a near fatality from an elderly woman being severely beaten by a younger patient. She put in her resignation, along with her husband's, not long afterwards.⁴¹

Hitch did not wish to sever completely his connections with the asylum at this point, and the Visitors clearly did not want to lose his services. He was able to negotiate a favourable arrangement whereby he maintained an overall direction, while divesting himself of many of the day-to-day responsibilities. He was appointed as consulting physician at £300 per annum, and was no longer required to be resident. He was expected to visit the asylum and see all the patients daily, retaining responsibility for their treatment, care, and management. A resident medical officer would be appointed, under his direction, to dispense the medicines, supervise the staff, and superintend the 'general economy' of the asylum.⁴²

Matters did not, however, proceed altogether smoothly then. Although the new arrangements did appear favourable, Hitch sought a further degree of independence. His achievements had opened up the opportunity for a lucrative private practice. This had a clear appeal to him, with his experience of the more congenial work with the first and second class patients in the asylum. A new agreement was made in August, whereby he was allowed to take four private patients into his own house at up to five guineas per week, provided he took on no interest in any other private asylum. His salary was to be reduced to £200 per annum accordingly. However, there was strong objection to this principle from the chairman of the asylum's subscribers, and the agreement was rescinded three weeks later. Hitch was made to sign the Visitors' minutes to confirm his assent to not taking private patients.⁴³

The new resident medical officer, Dr T.H. Huxley, did not remain very long, doubtless feeling the limitations of his office; in June 1846, he was appointed to be the superintendent of the Kent county asylum, and was allowed to leave with little notice. Hitch then resumed the superintendence of the asylum for three months, pending the appointment of a replacement for Huxley, but before the three months were up there was conflict. He was called before the Visitors in September to explain the several escapes of a patient allowed to work in the garden. The man, Oliver Freeman, had proved violent and dangerous when at large, and the Visitors ordered that in future, he be not permitted outside the walls without an order from the committee. Hitch dissented and recorded in the minutes his 'wish to avoid the responsibility of retarding his cure by restricting his liberty'. He clearly resented the restriction placed on his professional judgment and on his preparedness to take risks in the interests of a patient's rehabilitation.⁴⁴

Four months later, in January 1847, the Visitors gave notice of an intention to

alter Hitch's contract. From midsummer, his visits were to be reduced to three times per week, or more often in emergency if required by the superintendent, Dr Williams. His salary was to be reduced to £150 per annum. He was still required to live in Gloucester or in the vicinity of the asylum, but was now to be 'unfettered' as to private practice and to receiving patients into his house. Relationships were now becoming uneasy, and in October Hitch wrote to the chairman to advise that he had taken a mansion near Cheltenham, Sandywell Park, and proposed to seek a licence for its use as a private asylum. The committee deemed that he had in effect abrogated the agreement between the asylum and himself, and resolved to place its entire management in the hands of Dr Williams. Hitch's services were duly acknowledged, with expressions of regret for the termination of the 'intimate connexion' that had so long existed between him and the asylum. He was thanked for the 'humane and skilful treatment he has invariably evinced towards all classes of patients'.⁴⁵

Thus ended rather unsatisfactorily Samuel Hitch's tenure of office at Gloucester, which had lasted for almost 20 years. He had reached a point where he was no longer suited to the work of a medical officer in a county asylum. He resented the bureaucratic controls which were placed on his clinical judgment, and on his freedom to implement progressive policies which were in advance of the legal restrictions. The management of a private asylum offered the opportunity to implement his own methods unhindered. He continued to be active in the AMOAH, remaining as secretary until he resigned in 1851, and he still carried on as its treasurer until he withdrew in 1854. The remaining years of his life, however, were characterised by frustration and disappointment. He maintained the asylum at Sandywell Park, with the help of his daughter and son-in-law, until about 1865, when his habitual extravagance forced him to sell it to pay his debts. During much of the remainder of his life, his financial difficulties and repeated requests for money were a source of embarrassment to his family as well as himself. Widowed twice, his third marriage was an unhappy and acrimonious one. His death in September 1881 at his home in Eastbourne appears to have followed a self-administered overdose of laudanum. His passing was barely noticed in the medical press. No obituary appeared in either *The Lancet* or the *Journal of Mental Science*.⁴⁶

Samuel Hitch's lapse into relative historical obscurity remains something of a mystery, considering his acknowledged role in the development of psychiatry as a cohesive profession. Certainly, he did not achieve the celebrity or notoriety of those of his contemporaries who were the chief protagonists in the great non-restraint debate. However, his achievements at Gloucester, quite apart from his work in establishing the AMOAH, were considerable, and some of his innovations were well in advance of their time. There perhaps lay the problem. Commissioners and committees remained wary of practices that were out of the ordinary, appeared experimental, and which exhibited a significant element of risk. Ultimately, it was Hitch's adherence to his vision, and his single-mindedness, that drove him out of public institutional practice, and also derived him of a more prominent place in the history of British psychiatry.

Notes

- 1 The preparation of this chapter has been completed with the benefit of generous assistance from the Wellcome Trust.
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- 3 Outterson Wood, 'The Early History', 259.
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Family background information supplied by Sir Crispin Tickell, for which I am most grateful.
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G.O. Paul, *Observations on the Subject of Lunatic Asylums* (Gloucester, 1812), 43-55; *Doubts Concerning the Expediency and Propriety of Immediately Proceeding to Provide a Lunatic Asylum at Gloucester* (Gloucester, 1813).
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Walk and Walker, 607.
C. Crommelinck, *Rapport Sur Les Hospices D'Alienes De L'Angleterre, De La France et De L'Allemagne* (Courtrai, 1842), 108-9.
GCRO, H022/1/1, 31 March 1813.
- 6 GCRO, H022/1/1, 5 July, 2, 16, 22 AUUST, 4 October 1822; 16, 23, 30 January, 13, 27 February, 1 August 1823.
- 7 GCRO, H022/1/1, 1 January, 12 July 1824, 2 May 1825, 28 April 1829.
- 8 GCRO, H022/1/1, 13 January, 28 April, 14 July 1829, 25 March 1831, 16 October 1833, 30 January, 13 February 1840; H022/26/8; H0/22/6/9.
- 9 A. Scull, *The Most Solitary of Afflictions: Madness and Society in Britain, 1700-1900* (London, 1992), 167-9.
J. Walton, 'The Treatment of Pauper Lunatics in Victorian England: The Case of Lancaster Asylum, 1816-70', 175-6, in A. Scull (ed.), *Madhouses, Mad-Doctors and Madmen: The Social History of Psychiatry in the Victorian Era*, (London, 1981), 166-7.
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- J. Walton, 'The Treatment of Pauper Lunatics'. Walton's excellent article does tend to confuse 'moral treatment' with 'non-restraint'.
- R. Porter, *Mind For'd Manacles; A History of Madness in England from the Restoration to the Regency* (Cambridge, 1987), Chap. 4.
- A. Scull, 'Moral Treatment Reconsidered', *Psychological Medicine*, IX (1979), 421-8.
- 12 S. Tuke, *Description of the Retreat* (York, 1813).
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- 13 GPL, J7.26, 'Rules and Regulations for the Government of the General Lunatic Asylum of the County and City of Gloucester' (1823), 10-15.
- 14 'Rules and Regulations', 10-15.
- Crowther, *Management of Madhouses*, 41-72.
- 15 GCRO, D3848/2, 23 October 1828.
- K022/1/1, 12 May 1832; H022/3/1, 2 June 1832.
- Gloucester Journal*, 28 April 1832.
- 16 GCRO, H022/1/1, 17 October 1834, 14 April, 19 October 1835.
- 17 GCRO, H022/3/1, 28, 29 May, 24 September 1830.
- 18 GCRO, H022/1/1, 12 May, 7 October 1832, 2 January 1833.
- 19 GCRO, H022/1/1, 6 October, 26 December 1836, 2 April, 8 October 1838, 23 September, 7 October 1839; H022/3/2, 2 November 1835, 1, 2 July 1839; D3848/1/46, 26 January 1839, Crawley to Hitch (quote)
- 20 GCRO, H022/1/1, 26 December 1836; H022/3/1, 10 August 1832, 25 April 1834 (quote): H022/3/2, 1 July 1839.
- 21 PRO, MH12/13288/18261, Report of the Insane Poor Confined in the Workhouse, Birmingham, 31 October 1844.
- 'Rules and Regulations', 21-22.
- Cf *Rules, Orders and Regulations of the General Lunatic Asylum Near Nottinham* (Nottingham, 1825; copy in Nottingham Central Library), G. Higgins, *Rules for the Management of the Pauper Lunatic Asylum for the West Riding of the County of York* (Wakefield, 1821; copy in Wakefield Public Library).
- L.D. Smith, 'Behind Closed Doors; Lunatic Asylum Keepers, 1800-1860', *Social History of Medicine*, I, 3, 301-327.
- GCRO, H022/3/2, 15 March, 2 August, 1841, 14 March 1842, 11 November 1844.
- 22 Crommelinck, *Rapport sur les Hospices*, 115.
- Prichard, *Treatise*, 47-70, 261-2 (quote).
- R.G. Hill, *Total Abolition of Mechanical Restraint in the Treatment of the Insane* (London, 1839), 45.
- Shute was appointed physician from the time the asylum opened, GCRO, H022/1/1, 13 March 1823.
- Public Record Office (hereafter PRO), MH12/6470/18259; MH/12/13288/18261 (1844 quote). In Hitch's diagnostic summaries of the lunatic patients in the Leicester and Birmingham workhouses in October 1844, he uses the term 'moral insanity' to describe several cases. He referred to Selina Cooper in Birmingham as: 'A case of Moral Insanity, which with kindness and care might be much improved and the poor girl made a highly useful person of – at least deprived of her vicious propensities and encouraged to the indulgence and practice of better.'
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- 24 GCRO, H022/1/1, 15 July 1828, 2 January 1833, 2 April 1838, 24 January 1839, 6 April 1840, 21 June, 11 October 1841, 4 March 1844; H022/3/1, 15 May 1833; H022/3/2, 11 January 1836, 27 April 1840, 23 February 1841; H022/8/1, Annual Reports 1825, 1837, 1841, 1842.
- Report of the Metropolitan Commissioners in Lunacy* (1844), 132.

- 25 GCRO, D3848/1/1, 14 October 1839, Truebody to Hitch, 17 November 1840, Bosley to Hitch, 11 May 1841, Rich to Hitch, 7 October 1840, 30 December 1841, McGregor to Hitch; G3848/1/2, 6 July 1843, W. Roberts to J. Roberts.
- 26 GCRO, H022/3/2, 21 December 1840.
- 27 J. Walton, 'Treatment of Pauper Lunatics', 170-4.
L.D. Smith, 'Behind Closed Doors', 320-1.
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Lincolnshire Archives, LAWN 1/1/4, Lincoln Asylum, Committee Minutes, 2 March – 8 July, 1840.
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- 31 GCRO, H022/8/1, Annual Reports 1842, 1843.
Metropolitan Commissioners in Lunacy, 132.
- 32 C. Mackenzie, *Psychiatry for the Rich: A History of Ticehurst Asylum, 1792-1917* (London, 1992), 43, 85, 140-1.
L.D. Smith, 'To Cure Those Afflicted with the Disease of Insanity: Thomas Bakewell and Spring Vale Asylum', 122-3, *History of Psychiatry*, IV (1993), 107-27.
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- 33 GCRO, H022/1/1, 21 June 1841.
- 34 GCRO, H022/1/1, 11 October 1841: H022/3/2, 31 January 1842; H022/8/1, Annual Reports, 1841 (quote), 1842.
- 35 GCRO, H022/1/1, 11 October 1841; H022/8/1, Annual Reports, 1841-3.
Crommelinck, *Rapport sur les Hospices*, 112-14.
- 36 Walk and Walker, 'Gloucester and the R.M.P.A.', 613.
GCRO, H022/37/1.
- 37 GCRO, D3848/1/1, 1 October 1844, Rutter to Hitch.
Metropolitan Commissioners in Lunacy, 166.
- 38 GCRO, H022/3/2, 20 November 1843, 15 February, 26 August, 2, 21 September 1844, 17 February, 30 May 1845.
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Metropolitan Commissioners in Lunacy, 98-9, 234-5.
- 39 PRO, MH12/6470/18259, especially pp.7-9, 13; MH12/13288/ 18261. I am grateful to Dr Peter Bartlett of the University of Nottingham for guiding me to this material. His thesis, 'The Poor Law of Lunacy: The Administration of Pauper Lunatics in Mid-Nineteenth Century England' (Ph.d, Univ. of London, 1993), refers several times to the Leicester report and indicates its significance. In Birmingham workhouse there were two sections set aside for the lunatics – the 'Asylum Ward' and the 'Mad Garret'.
- 40 MH12/6470/18259, Appendix; MH12/13288/18261.
- 41 GCRO, H022/1/1, 19, 24 March 1845: H022/3/2, 6, 13 January 1845.
Crommelinck, *Rapport*, 109.
- 42 GCRO, H022/1/1, 2 April 1845.
- 43 GCRO, H022/1/1, 6, 20, 30 August 1845.
- 44 GCRO, H022/1/1, 23 June, 15 September 1846. Huxley appears to have been one of Hitch's early students in the training scheme at Gloucester (H022/3/2, 12 September 1842). He evidently remained a long-term friend and protégé.
- 45 GCRO, H022/1/1, 27 January, 16 October 1847.

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Walk and Walker, 629.

Outterson Wood, 'The Early History', 255, 259.

GCRO, D4183/2/7. I am grateful to Dr David Hirst of the University of Wales, Bangor, for guiding me to this collection of material.

Thanks are also due to Sir Crispin Tickell, and to Ms Julie Beckwith, Assistant Librarian at the Royal College of Physicians, for biographical information provided.

24 The Father of Psychophysiology – Professor F. L. Golla and the Burden Neurological Institute

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Part 1 F.L. Golla

Frederick Lucien Golla was the first Director of the Burden Neurological Institute, a post he took up at the age of 62 and only reluctantly left at 81. He was a reserved, private man, publishing relatively little and, outside the Burden, is little remembered. Yet his influence on psychiatry in this country, as well as world generally, was considerable. In many ways, he was the voice behind much of the progress in the understanding of brain function and dysfunction which has taken place in neuropsychiatry over the last 70 years.

Golla was born in London on 11 August 1878. His father, Lucien Golla, was the son of a Piedmont Italian who had come to Britain from Italy. The family was wealthy with aristocratic connections and Golla was proud that his grandfather was one of Garibaldi's 'Thousand' and had fought with the guerrilla leader for the independence and unification of Italy.

Golla did not have a high opinion of his father, who, it was said by Grey Walter, did very little before retiring to Naples. Golla's main annoyance with his father was that he had sent the young Frederick to Tonbridge School instead of one of the more prominent English Public Schools. Nevertheless, Golla did well and went on to Magdalen College, Oxford. He graduated BA in 1900 and went on to his clinical studies at St George's Hospital in London, graduating BM, BCH in 1904. He worked as a house physician and house surgeon at St George's and then, following his early and abiding interest in neurology, became resident at the National Hospital in Queen's Square, which was (and still is) the country's leading neurological hospital. Here, Golla came under the influence of the two great pioneers of modern neurology and neurosurgery – Hughlings Jackson and Victor Horsley. Golla assisted Horsley in the earliest direct measurements of intracranial pressure, using a tambour placed in a trephine hole in the skull. He also worked for Dr (later Sir) Gordon Holmes, another eminent neurologist, who thought highly of Golla's abilities.

In 1907, he was admitted as a Member of the Royal College of Physicians. He would account in later years (possibly tempering the anxiety with the passage of time) how he gained admission by sitting drinking tea with a senior Fellow and discussing patients they had seen – so much more civilised than today's unpleasant scramble through computerised multiple choice papers and essays.

After this, in 1908, he was appointed to the staff of St George's Hospital as an assistant physician. He was also on the staff of the West End Hospital for Nervous Disorders and, in 1913, of the Maida Vale Hospital. In 1908, he married Therese d'Hausaire, who sadly died during the Great War from a fever, which Golla always felt she had caught from him. They had one daughter Yolande, who worked at the Burden in the early years after its foundation in 1939.

In 1909, he published his first paper – a 'preliminary note' on the clinical value of the antitryptic power of serum in tuberculosis (Golla, 1909). Golla gives a description of how to take blood from an arm with a syringe ('the skin is first sterilised and the patient requested to look in another direction') – clearly this was not a routine technique at that time, puncturing a finger or the ear and squeezing out blood being more common. Although Golla did not follow-up this early work, his interest in using electricity at that time is demonstrated in it since the investigation involved measuring the electrical conductivity of a solution of protein and an enzyme (casein and trypsin) as it changed over time, due to the digestion of the protein. This effect is slowed by serum from blood, and Golla attempted to show that it was different in patients with tuberculosis, especially if they were not responding to tuberculin treatment. This work was carried out on patients from St George's Hospital, but done in the Physiological Laboratory of the University of London in South Kensington.

In 1913, Golla published the first of a number of articles on respiratory function, this being a non-clinical physiological study on animals investigating the effects of adrenalin, nor-adrenalin, and various other chemicals on the constriction of bronchiolar and tracheal muscle (Golla & Symes, 1913).

When the Great War started, Golla enlisted as a lieutenant in the Royal Army Medical Corps, and served in France, where he was Mentioned in Despatches. He then served on various War Office Committees and took a special interest in the psychological aspects of trench warfare. He rose to the rank of Captain and was appointed OBE in 1919 for his services. It was during this time that he came to know Sir Frederick Mott, Director of the London County Council Pathological Laboratories, a post which Golla eventually took over from him. Mott's special interest during the war was 'War Neurosis', a subject on which he published an important monograph.

Golla – no doubt influenced by his experiences of warfare, his work on the committees, and his relationship with Mott – extended his interest from relatively straightforward physiology to studies of measurable change occurring during alterations (both normal and abnormal) in the mental state of individuals.

Sir Frederick Mott had been Director of the Pathological Laboratory of the Claybury Asylum since 1895, and was a most eminent neurophysiologist and neuropathologist, with a first-rate record of scientific work before Golla came into contact with him. He had been vital to the process of founding the Maudsley Hospital for the treatment of patients, rather than merely an asylum for the mentally ill. His laboratories were transferred from Claybury to the Maudsley Hospital, and it was to these that Golla came after the War. He also returned as a Consultant to St George's Hospital and carried out some research with Sherrington, the great physiologist. The culmination of his research work in the field of mental illness was the presentation, in 1921, of the Croonian Lectures to the Royal College of Physicians of London, all four of which were published in *The Lancet* under the title of 'The objective study of neurosis' (Golla, 1921).

In these lectures, Golla tried to establish that neurosis could be understood in terms of physical changes and failures of organic equilibrium, and that it could be assessed using physiological methods. He wrote that, 'We are, I think, right in assuming that an organic disability exists as an antecedent to every neurosis'. In this, he was embarking on, if not founding, the science of 'Physiological psychology' as he called it (now renamed 'Psychophysiology').

Golla would have been influenced in this view by two major experiences. First, he had undergone his medical training at a time when one of the main forms of mental disorder (General Paralysis of the Insane) was found to be due to a very earthly organic cause, the *Treponema pallidum* (syphilis). His great mentor, Mott, was the first in Britain to demonstrate this fact. The second factor was his experience of trench warfare. At the start of his Croonian Lectures, he wrote, 'Doubtless all of us who were in the lines showed for a longer or shorter period the disturbances due to fatigue or functional hypertrophy of certain nervous mechanisms, but only those succumbed who were organically unsound'. And with a mixture of pride and resentment that marks him out as an old soldier, he wrote 'Had those who have contributed to the literature of the war neuroses been permitted to undertake regimental duty in the line, thus to know their men, as one can only do by constant contact, they would have found little difficulty in spotting the future cases of neurosis before even a shot was fired'. His own reaction to such stress was to fall asleep.

Thus Golla clearly believed, even before scientific proof, that organic disability existed as an antecedent to neurosis. His quest at that time and throughout his life was to discover objective methods for evaluating these organic physical bases for both normal and abnormal mental activity. He was inclined, at this stage, to discount the preceding life experiences of the individual. Nevertheless, he was not entirely mechanistic, even at this less mature stage, and allowed that he was 'compelled to admit the existence of much that, from its incommunicable nature, falls outside the sphere of physical reality'.

The four Croonian Lectures are based largely on Golla's own experiments and observations – often on himself and with home-made equipment. They are full of homely examples and impressions, as for instance with his description of his own ability to recall musical pieces (even 'though I am told that I have a fairly good ear') and in his description of what happens to eye movements when 'asking an unsophisticated subject to describe to me Trafalgar Square as he would see it if he stood at the base of Charles I's monument'. One should not look down on these simple, perhaps, simplistic, observations; since scientific method and medical investigation were in their infancy, especially in the fields of psychology. However, he recognised that his conclusions needed a great deal of further working over.

In describing his experiments, Golla first suggested that there is always a 'mode of movement', so that the larynx may move even if no speech emerges, the eyes will move when visual thinking is taking place, and preliminary muscle movements will occur whilst awaiting an instruction to move. This latter effect, is conceptually rather similar to the Contingent Negative Variation (CNV) or 'expectancy wave' on the EEG that was discovered at the Burden Neurological Institute some 40 years later. Golla also made a number of observations both about people with auditory representations of memory and those with visual representations 'I have the impression that men with a predominantly auditory

type of representation are less nice about physical matters and that the visualist is less nice about the choice of words and less prone to take umbrage at a harsh expression'.

A large part of these Croonian Lectures is based upon Golla's pioneering work in the study of electrical responses of groups of muscle – electromyography (EMG), now a flourishing science in its own right. One of his major contributions was to describe the 'Tonic effort reflex' by both EMG and other more direct physical observations ; this 'reflex' is the increase in muscle tone (tension) with mental or physical effort, greater increases occurring with greater mental effort. Golla constructed his own instruments to record muscle tone in the leg and neck – often with great ingenuity – which also was a strong feature of later work at the Burden. Other muscle groups and bodily functions investigated by Golla included respiratory, cardiovascular, and visceral reactions.

The second lecture described his experiments on the effect of 'effort on sensation using the "Galvanic Skin Response" (GSR)'. When an individual sweats, the electrical conductivity of the skin increases and this can be measured. Although this phenomenon had been described independently in France and Germany before the turn of the century, it was Golla's work which drew it to the attention of the wider scientific and medical world and established it, for decades, as a major psychophysiological method. The GSR is still a subject of research and is, part of the 'lie detector' technique used across the world. Golla maintained that the GSR is not under voluntary control and cannot be induced by thinking about being fearful, only by actually being so. With his (at that time) almost entirely mechanistic view of man, he had no time for the unconscious, 'to talk of subconscious feelings is, of course, to talk nonsense'.

Using the GSR, Golla was able to demonstrate a progressive diminution of response to a repeated stimulus (nowadays called habituation), He (rather quaintly, but accurately) called it 'Progressive Indifference'. This observation forms one of the vital bases of psychophysiology.

Taking this notion further, he demonstrated, the conditioned reflex physiologically. This, he considered, illuminated the relationship between bodily response and affective state, and explained, many of these experiences which lead us intuitively to a non-mechanistic view of human emotion and response, but which could be explained in straightforward physical terms.

In addition to the GSR, Golla described experiments which he had carried out using other signs of physical response to unpleasant stimuli, where benign stimuli do not lead to changes in the opposite direction. He concluded, like the Greek philosopher Anaxagoras, that 'Pain is the fundamental fact and pleasure nothing but the relief from pain'. Again, perhaps, we see the philosophy of the war veteran in this view.

Golla went on in the next two lectures to discuss how his observations related to real-life situations and people – firstly how they might illuminate the normal emotion of every day life and secondly, how they might help increase understanding of neurotic states. In these lectures, Golla relied rather more on opinion, philosophical discussions, and one-off personal observations (often of his own person) than on scientific experimentation.

In the third lecture, he expanded on the theory of the psychologists James and Lange that bodily manifestations result in and form the whole basis of emotion. Instead of the usual presumption that we cry because we are sad, they proposed

that 'we feel sad because we cry, angry because we fight, afraid because we tremble'. Golla, one might suppose from his mechanistic viewpoint, agreed with this view and he produced some work with the GSR to support it. However, his own personal experiences seemed to carry more weight, 'introspection seems to confirm the objective data . . . in the streets of London my absence of mind has frequently involved me in a road accident' and goes on to say that after successfully avoiding disaster, he feels 'hot all over' before feeling fearful.

After considering the part which hormones might play in affecting sensation and responses to stimuli (which he felt was greatly over-estimated), he went on to discuss the role of conditioned reflexes in daily life, and indeed the role that inherited reflexes (instinct) have in human behaviour. As an example, he used his observation of 'nest-making instinct' in a young mother-to-be of his acquaintance. Thus did Golla rationalise (or reduce) much of human behaviour to physiological reactions, conditioned responses, or instinctive reflexes.

In his fourth and final lecture, he discussed how physiological ('objective') psychology can be applied to the study of neuroses. At the outset he stated, boldly that, 'the nervous system is an instrument of movement and nothing else' so that the functional disturbances termed neuroses must be the expression of some chemicophysical changes affecting movement of the neurones generally. He set out to dispose of the psychogenic theories of the origin of neuroses, saying that the work of Mott's laboratory had 'once and for all' disposed of the theories of the psychogenic origin of dementia praecox (schizophrenia). In spite of this, argument on this subject continued to rage for the next 60 years.

Finally, Golla described investigations which he had carried out on patients at the Maudsley Neurological Clearing Hospital established in the buildings of the Maudsley Hospital during World War One – where he had the opportunity of examining all the cases of neurosis which were admitted. He proceeded to discuss his findings in general, rather than in specifically scientific terms. These findings were based on a major division of neuroses into 'aesthetic' (what might today be termed 'depressive'), 'hyperexcitable', and 'hysterical'. He produced evidence of easy fatigability in aesthenics and of an excessive response of the skin to a small injection of adrenalin into the epidermis in hyperexcitable patients. Golla then commented on the need for 'Constitutional Treatment' in these two groups of patients, and cast faintly disguised scorn on the psychoanalytic methods of treatment which were becoming increasingly popular.

He then moved on to the patients with hysterical disorders, in which symptoms (e.g. a paralysis) could be produced by an act of will, without apparent neurological cause or conscious simulation (malingering). In spite of this, Golla took the view that hysteria, like other neuroses, is the expression of an organic disturbance, and he had sought this disturbance using his trusty GSR. In fact, he advocated a continuous assessment of the GSR whilst the patient tells his history to the doctor. Golla finds that the patient with hysteria is, firstly 'always more willing than a well bred person should be to impress his fellows', so that his GSR may remain unresponsive, whilst telling, in dramatic and ill-bred fashion, of his past and present traumas and distress. Golla regarded this and other evidence as proof that the fundamental problem in hysteria is 'an organic disability of the organ of affection', so that the patient no longer has that 'strongest bond with reality' which is our feeling – those things – 'which constitute our strongest defence against the

irrational'. He concluded that the 'mind disassociated from feeling is mind very much at the mercy of suggestion'. Thus Golla considered the neuroses to be organic disabilities demonstrating characteristic psychophysiological changes from normality, which he regarded as evidence of some central neurological dysfunction. The Croonian Lectures have been examined here in some detail since they form the summary and in some senses the conclusion of Golla's major personal scientific work. He went on to supervise and stimulate others and to be involved in some rather intermittent personal research, but did not return to a major concerted personal research effort.

What then can be said of the scientific worth of Golla's personal research? At the time, an anonymous contributor who summarised the papers for the *Lancet* rather damned them with faint praise: 'when we turn to the evidence adduced . . . we confess to a certain feeling of disappointment' and 'an ingenious theory of nature and aetiology (causation) is adumbrated rather than worked out'. Overall, the reviewer felt that, 'the value of the research of Dr Golla resides less in the conclusion tentatively advanced than in the orientation they exhibit', adding that 'to travel hopefully is a better thing than to arrive and the true success is to labour'. Later reviewers, of which there have been few, were perhaps kinder. His junior colleague, Alfred Meyer, called it a noteworthy contribution which 'certainly established Golla's reputation as a serious experimental worker, with fresh ideas on a difficult subject' (Meyer, 1973).

One of the difficulties is Golla's almost impenetrable prose style and an organisation of the subject matter which is not easy to follow. He rarely summarised – one cannot look at the last paragraph of a section to get the gist of it; the only way is to wade through the whole piece. He appears to impress more by overall form than by content. There is also, perhaps strangely, a slight feeling of dilettantism about the work – a subject here, a little experiment there, but nowhere the slogging, single-minded scientific research which was needed to make creditable advances.

Whilst a neurologist at St George's, he was always considered shy and reserved, rarely to be seen on the hospital medical committees. However, his clinical acumen and caring attitude towards his patients was widely recognised, even if his methods of treatment were a mixture of very advanced (he was the first in the hospital to treat epilepsy with the new drug phenobarbitone) and rather archaic drugs (using mercurial inunctions for the treatment of syphilis at a time when the newer arsenical drugs were in common use). One of his obituarists, who was a colleague at the hospital, wrote that 'oddly enough, for a man with considerable physiological knowledge and ability, his clinical approach to patients was often by way of an empirical art . . . I do not think that Golla was ever really interested in purely clinical medicine, and certainly not in private practice and its rewards'.

Golla carried on with further experimentation at the Maudsley laboratories, under the encouragement of Sir Frederick Mott. In 1922 with Joseph Hettwer, he published a short paper concerning the effect of various physical factors on the knee jerk reflex (Golla & Hettwer, 1922) – factors such as frequency of tapping the patellar tendon. Golla & Hettwer invented a machine capable of tapping more than 20 times per second.

All this work brought Golla to the attention of the medical scientific establishment and in 1923, when Mott retired, Golla applied for and was appointed to the position of Director of the Central Pathological Laboratories at the Maudsley

Hospital. One of Golla's referees for this post was Sherrington – the original reference, in Sherrington's handwriting, is in the Burden library.

The position of director of the laboratories was very influential. It carried with it the automatic directorship of the Medical School of the Maudsley Hospital and Golla was therefore responsible for the academic training of all the young psychiatrists attending what was becoming the country's premier psychiatric hospital. He took over the responsibility for lecturing and arranged lectures in the 'courses of instruction in psychological medicine'; he also set up fellowships for prominent young psychiatric and neuropsychiatric scientists to work in the laboratory.

In 1926, Golla wrote an article describing the work of the laboratory in the house journal which he now edited. The laboratory occupied a wing of the Maudsley Hospital and contained departments for the study of pathological anatomy, biochemistry, physiological psychology and bacteriology – the staff consisting of himself and a scientist leading each of the departments. He described the rooms available, including the lightproof room in the basement where much of the EEG work was to take place. Golla defined three functions of the laboratory; firstly, to investigate pathological material from the Maudsley Hospital and the ten London County Council mental hospitals; secondly, to carry out and organise research in all those hospitals; and thirdly, the tuition and training 'in scientific pathology' of the medical officers of the hospitals.

Golla's influence then spread far and wide throughout all the major psychiatric hospitals of London as well as the Maudsley. This influence was enormous and, at least potentially, much greater than that of the head of any psychiatric department in a teaching hospital. He took on responsibility for the scientific training of all psychiatrists in London, other than those in the few, small teaching hospital departments. He was responsible for inspecting all the mental hospitals' pathological departments and for buying and lending all special equipment. He arranged for medical officers from the other hospitals to be seconded to his laboratory, operated as a central resource for scientific references (setting up an important central reference library), and arranged monthly meetings for all the psychiatrists, chaired alternatively by himself and the Medical Superintendent of the Maudsley Hospital. At these meetings, the psychiatrists presented clinical cases, so that this was fertile ground for influencing the actual clinical management of patients throughout London. The Medical School at the Maudsley Hospital had been set up by Mott, and recognised by the University of London specifically for the purpose of training postgraduate psychiatrists taking the higher qualification of the Diploma in Psychological Medicine. Thus, Golla presided over the forerunner of the country's present postgraduate training centre – the Institute of Psychiatry – which is regarded as one of the world leaders in psychiatric teaching and research. In his quiet way, by personal contact, academic encouragement, and collaborative research, Golla profoundly influenced a whole generation of London psychiatrists.

Golla was at the Maudsley from 1923 until 1939. For much of that time, the Medical Superintendent was the prominent and determined psychiatrist Edward Mapother. Their relationship seems to have started smoothly enough, but stories still abound concerning their developing personal animosity over the years. Though not documented, personal communications suggest that in the end, Golla would not allow Mapother to cross the threshold of his department.

Once Golla was established as the Director of the laboratory, he began encouraging people and money to come to the Maudsley. Many of the scientists, who were later to be world renowned figures in psychiatric research were drawn to the Maudsley because of the quality both of its research and teaching. These included Gottesman, Meyer-Gross, Slater, Mapother himself, Aubrey Lewis, Richter, and many others. These young physicians and scientists were attracted and held by Golla's wide grasp and vast knowledge of the whole field, by his superb lectures in the academic courses, and by his assiduous encouragement of their research. For whilst Golla did not do much personal research, there being more involved in administration and teaching, he had many fruitful ideas which others could take up and work on. He would then carefully supervise their work, coming round each day to enquire whether there were any problems and to talk about the ongoing work.

Golla's method, having provided the facilities (the laboratory), was to go out in search of the right people. Derek Richter describes how he was working in a laboratory in Cambridge, doing biochemical research, when Golla came round in search of a biochemist to develop a test for measuring amphetamines in the blood. Richter responded to this opportunity and came to work in Golla's lab, developing the assay successfully. One of the most fruitful of such expeditions was when Golla, having read Berger's first paper on the human EEG, poached Grey Walter from Adrian's laboratory in Cambridge.

Although Golla then did rather less personal scientific work than some of his contemporaries, he made at least three major contributions to brain science. Firstly, with Hettwer, he was the first to investigate the human electromyogram – the recording of the electrical activity of muscles as a measure of their tension and responsiveness. The EMG is now a standard part of neurological diagnostic practice and has led to greater understanding of muscle disease and greater accuracy of diagnosis; Golla published this pioneering work in 1924 (Golla & Hettwer, 1924).

A second investigatory technique which he developed was a reliable method of measuring the speed of conduction of the impulse in human nerves (both motor and sensory). This work, carried out with Antonovitch and published in the early 1930s (Golla & Antonovitch, 1931, 1933), was based on the previous attempts of others, but Golla's careful scientific methodology allowed much more accuracy to be achieved. The measurement of conduction velocity is today a vital part of neurological investigation.

Golla's third major personal scientific contribution was his work with S. A. Mann and R. G. B. Marsh on the response of psychotic patients to carbon dioxide gas (Golla et al, 1928). This work was done using equipment (an automatically controlled plethysmograph) which he had developed himself. Golla and his co-workers demonstrated that patients with 'psychosis' (all forms) did not respond to inhalation of carbon dioxide with increased respiratory ventilation as did 'normal cases'. This was a clear anticipation of the important concept of 'physiological withdrawal' and the concept of an 'adaptation syndrome' in patients with psychosis, particularly schizophrenia. It is the concept that the patient with schizophrenia finds the world so confusing and frightening that the body reacts in a protective, adaptive fashion by not responding to the multiple inputs of the world and withdrawing into a protective inner world. However, Golla did not hypothesise that far, but

merely stated his physiological findings and left it for others to develop the idea.

Whilst at the Maudsley, Golla published further work on the knee jerk reflex – which, to his disappointment, he found unrelated to purely mental effort (Golla & Antonovitch 1926b). There was also a short paper demonstrating that psychotic patients with brain tumours were more likely to have them in the temporal and frontal regions (Golla, 1931) – an early demonstration of the importance of these regions of the brain in psychotic symptomatology and a small contribution to our understanding of the origin of schizophrenia.

During the 1930s, Golla was certainly one of the most prominent men in the field of psychological medicine in Britain. Evidence of the esteem with which he was held included being elected president of the Neurology and Psychiatry Section of the Royal Society of Medicine – his Presidential Address entitled ‘The Nervous System and the Organic Whole’ was a masterly exposition of his view of the vital importance of physiological observation and reaction (Golla, 1935). However, by that time, his view of the functioning of the nervous system had been affected by what Slater later called a ‘refreshing breeze’ – that of Gestalt psychology. This school takes the view that the whole is greater than the sum of the parts. Hence, Golla saw the total functioning of the person (the organism) as much more than simply the sum of the activities of the nervous system. Indeed, his later reviewer, Slater (one of the brilliant young men encouraged to come to the Maudsley) regarded Golla’s view of science and psychiatry as ‘nihilistic and pessimistic’, since Golla seemed to be saying that scientific endeavour, being analytic, was bound to fail when attempting to explain human psychology.

In fact, as judged by Golla’s later efforts, his attitude was not in the least nihilistic or pessimistic, but he did come to feel (at least to some extent) that scientific investigation may not be able to explain everything about the individual and his or her functioning, since the activity of science is itself part of the whole. Indeed, it is part of the whole universe, which exhibits a continuous process of change. In this sense, Golla’s view may be seen as pessimistic, in that science cannot clarify everything, since it changes what it is attempting to clarify (a sort of uncertainty principle). Clearly, his views did not prevent Golla from greater understanding; rather, this added dimension rounded out his concept of the functioning of the human nervous system. Indeed, he ended this Presidential Address with the comment that, ‘I look forward to the day when a neurologist will be a humanist in the widest sense, when the psychiatrist will no longer shun the laboratory and the neurophysiologist will be the trusted collaborator of the psychologist’. Such was the idea that Golla attempted to set up, and largely succeeded in doing so, at the Burden Neurological Institute.

In 1937, Golla was invited to give the most prestigious address in British Psychiatry, the Maudsley Lecture (Golla, 1938). Entitled ‘Science and Psychiatry’, it expanded the views already expressed at the R.S.M and based much of the argument concerning the complexity of human functioning on work and observations described in his Croonian Lectures – for instance, his comment on the ‘nest building’ behaviour of mothers-to-be.

The task which Golla had set himself in this lecture was ‘to find a way from the dead world of science to the living world of purpose and values’, where ‘ethical, aesthetic, and religious considerations do not need to be deliberately excluded in the interest of a higher abstract account of conduct’. Golla had long been

a man of religious, Roman Catholic conviction. This clearly coloured not only his attitude to his life and his practice of medicine, but also his response to the questions of science and the functioning of the human organism. Golla's religious beliefs also resulted in him donating land and money to build a Roman Catholic church near his final home, Newlands on Frenchay Common in Bristol.

In 1937, the same year as Golla presented the Maudsley lecture, he was installed as Professor of Mental Pathology in the University of London – a position which finally recognised the vital part which he had played and was continuing to play in the training of scientific psychiatrists and the establishment of psychiatry as a scientific discipline. It was in this year that with S. A. Mann and W. Grey Walter he published the first description of the inter-ictal EEG in epilepsy – a landmark paper (Golla et al, 1937).

Having reached the apogee of academic recognition, one might have expected any lesser man, at the age of 60, to coast quietly into retirement. However, in 1939, he took on a further career as the Director of the new Burden Neurological Institute in Bristol. He went on gaining honours and recognition and was always thereafter referred to as 'The Prof', although he had only been in that position for two years. He was President of the Electroencephalographic Society and of the Society for the Study of Addiction as well as an honorary member of the Royal Medico-Psychological Association. On his 70th birthday, eminent colleagues and former pupils wrote and presented him with a book '*Perspectives in Neuropsychiatry*' as a mark of affection and respect.

Golla remained in clinical and scientific work until his eventual retirement in 1959 at the age of 80 and continued to see patients and advise occasionally until his death, at the age of 90 on the 6 February 1968. Even at the age of 80, he co-authored an important paper on a new EEG finding in migraine (the diagnostically useful 'H response' (Golla & Winter 1957).

During his lifetime, Golla was regarded with a mixture of strong feelings by those who had dealings with him. By many, those who did not know him well, he was regarded as aloof, reserved, somewhat arrogant, and with little time for others. He participated uneasily, if at all, in the Bristol medical establishment. But those who knew him well knew him to be warm and affectionate, a staunch ally and stimulating, erudite company. Even in his later years, he had a remarkable memory for scientific references and philosophical quotations. He would start 'I remember before the war . . . ' and it took the listener some minutes to realise that this was the first World War that he was talking about. Dr Joseph Jancar, a psychiatrist who took Golla out for frequent car rides in the Gloucestershire countryside in his later years, recalls Golla's last years as rather sad; the loss of his wife and only child left him a lonely man, although his patients and colleagues continued to come to him for advice and help.

Because of problems with the work as well as the fact that he was to some extent a lone voice crying in the wilderness, Golla has not been put in his rightful place in scientific history. He was writing at a time when the prevailing and exciting fashion was for the new Freudianism and a psychodynamic view of human behaviour. On the basis of the work described in his Croonian Lectures, Golla should certainly stand as one of the founding fathers of Psychophysiology, perhaps as the Founding Father. Many of his observations have been followed up,

often decades later and often without mention of his pioneering work. It seems possible that few of his later reviewers actually read the Croonian Lectures – it takes considerable stamina. Throughout this time, Golla was carrying out his extensive clinical duties at St George's Hospital.

The Burden Neurological Institute is a monument to Golla's scientific and managerial acumen and it should now be clear how his own personal fascination with the physiological basis of behaviour in the normal person and psychiatric patient led to the development of the Institute's work in this field. The work that Golla did before coming to Bristol on conditioned reflexes, hormones, GSR, respiration, EMG and the like was repeated and expanded many fold in the next 50 years and formed the basis of our modern understanding of psychophysiology.

Part 2 The Burden Neurological Institute

The brain research institute which Golla directed for 20 years takes its name from Rosa Gladys Burden, the second wife of the Reverend Harold Nelson Burden. Harold Nelson Burden was a man who devoted his life to the welfare of others, having worked initially in the east end of London, then with the Ojibway Indians of Canada and at Horfield prison in Bristol, before founding a number of Institutes around Bristol, the first being for alcoholics, the Bentry Institute for Inebriates in 1898. In 1902, Mr Burden founded the Incorporation known as 'National Institutions for Persons Requiring Care and Control' and became its first warden. Subsequent development of the Stoke Park Colony just to the north of Bristol, as the first Institution in Britain to be certified under the Mental Deficiency Act of 1913 for mentally retarded patients was as a result of his membership of the Royal Commission which inquired into the care of the 'feeble minded'. In 1909, the Dower House Estate of the Duke of Beaufort's family was acquired and became the nucleus of a group of Institutions later known as Stoke Park Hospital. Mr Burden's first wife, Katherine, died in 1919 and Mr Burden subsequently married Miss R. G. Williams, the first Superintendent of Stoke Park. The Reverend Harold Nelson Burden died in 1930 and Rosa carried on his work, becoming appointed as the second warden; she went on to manage the affairs of the Institution with great flair and understanding. Also, in 1933, she gave £10,000 for research underlying the cause and inheritance of normal and abnormal mentality, thereby establishing the Burden Mental Research Trust. This was not the same as the current Burden Trust which was formed in 1956 after sale of freeholds, relating to the Burden grounds, to the Ministry of Health in the 1950s.

In 1936, Mrs Burden was encouraged by a surgeon friend to build a small special Clinic for Medical Research, especially for the treatment of epilepsy and allied disorders of patients in Stoke Park and other institutions. This was to be an extension of the mental research already established, but was to be run as an independent unit directly under the guidance of Mrs Burden. The building was designed to form a complete neurosurgical unit with a well equipped theatre, two small wards, a library, laboratories and accommodation for nursing staff. Subsequently, Mrs Burden was unable to convince the Board of Control that such a unit would serve any useful purpose in connection with a colony of

mentally handicapped people. The hospital itself had been built and so Mrs Burden, naturally disappointed to find her generous gift unused, endeavoured to interest the clinicians of the Bristol Hospitals and university in a project for using it as a neurosurgical clinic for Bristol. However this 'failed by reason of the disinclination of the practitioners to work so far out of Bristol' (Stoke Park Annual Report, 1938).

Mrs Burden, being determined that this well equipped facility should not be wasted, sought the advice of the Medical Research Council with an indication that she might be willing to finance it as a research organisation. Professor Golla, who attended the meeting of the MRC, thought that it would be a great public service to establish in the west country a central research laboratory similar to that which he organised at the Central Pathological Laboratory of the Maudsley Hospital. This idea was enthusiastically adopted by Mrs Burden when it was put to her by Sir Lawrence Brock, Chairman of the Board of Control.

Golla wished to continue his research work untrammelled by official duties and, in any case, was coming towards retirement at the Maudsley Hospital. It is likely that he also realised that war was inevitable. He therefore undertook the Directorship of the new Institute which was to be set up at the Burden, with some considerable personal sacrifice since, under the London County Council rules, his pension rights were cancelled and his previous contributions were not returned.

The Burden Neurological Institute was built by Messrs James Carmichael (Contractors) Limited of Wandsworth, London to an estimate of £17,398. The work was completed in 1938 and the Institute was formally opened on 12 May 1939 by Sir Thomas Inskip, Secretary of State for the Dominions. A coach on the train from Paddington was specially reserved by Mrs Burden for her guests travelling from London. At the opening ceremony, Sir Thomas Inskip said 'There is not a more distressing feature of modern life than the number of people suffering from mental disorder. It is a work of true Christian charity that we should try every means humanly possible for helping them'. Professor Golla said 'We are behind practically every other country in Europe in the support given to investigation of brain disorders. The care of mental cases is chiefly in the charge of municipal and county authorities, and with the best will in the world, the first thing that they have to do is to look after their patients. They can only do little pieces of research and with such large numbers of patients coming and going any work of this description must be very difficult'.

From the opening day, Golla stressed that the Institute was concerned with a wider range of brain disorders than mental deficiency and he especially emphasised epilepsy and psychiatric disorders. He brought with him from London a team of scientists, including Mr W. G. Walter in charge of the Physiological Research Unit, Mr L. D. MacLeod and Mr Arthur Tingey as biochemists, and Professor Max Reiss in charge of the Endocrinology Unit. In 1938, Professor Reiss had had to flee from Prague, leaving his personal possessions behind but carrying his laboratory equipment and, it is said, managing to bring out a large oak table which is the current centrepiece of the Burden Institute library.

In less than six months after the opening ceremony, war started and the

Emergency Medical Service used the Institute as a neurosurgical hospital for the whole of the west country; it possessed the only neurosurgical theatre west of London. After the war, the neurosurgical unit moved to Frenchay Hospital, Bristol, where it continues to form the Sub-Regional Neurosurgical Unit. Despite the strain due to the requirements of the neurosurgical unit during the war, the laboratories continued to function as a centre for clinical research in psychiatry and neurology, under the directorship of Professor Golla. Golla had been appointed as Medical Director at a salary of £1,500 per annum. His principal assistant, Mr Grey Walter, was appointed at a salary of £800 p.a. The finances of the Burden Neurological Institute were, and remain, somewhat precarious. The initial allocation of £4,000 from the Trustees was largely covenanted, but a further £5,000 was given in 1939 in order to undertake research into epilepsy, by the Rockefeller Foundation, who continued to support this work for a number of years.

Professor Golla continued to run the Institute almost entirely on his own; there had been no meetings of the formally established Management Committee between 1940 and 1944. In 1948, when the National Health Service was established, Golla and the Committee of Management took the unusual step of electing to keep the Institute out of the NHS. Golla believed that the Institute, with a small number of beds, would appear unjustifiably expensive and would be discontinued so that its clinical and research activities would be merged into the routine of large public hospitals. Golla wrote in an internal report (1953) that 'Freedom of choice as to what problems should be tackled and by what methods and persons, involves a flexibility of approach and administration that is altogether alien to a government service. Above all things, research workers need the psychological stimulus of freedom of both thought and action'.

Though not in the Health Service, patients were seen under contract with the Regional Hospital Board; 8 guineas a week was paid for each patient. Payment for brain recordings (EEGs) was arranged through the Regional Hospital Board by paying £1,600 per annum to the Director as his salary and this money was then given by Golla to the Institute. Only in 1975 was there a formal contract between the Institute and the NHS for specialised neurophysiological services.

The perennial problem of assured income remained with the Institute and, in an attempt to break out of this hand-to-mouth system of funding, Golla obtained the substantial grant of £40,000 spread over 7 years from Arthur Guinness, Son and Company to carry out research 'into the therapeutic value of alcohol'. Unfortunately, this work (perhaps not surprisingly) did not prosper and there was considerable pressure from Guinness to change the Director, who was now in his 82nd year. At a special meeting on 14 October 1958, attended by only 2 other members, Professor Golla was persuaded to resign. For a brief and unhappy period Dr W Ross Ashby (a world leader in the infant science of cybernetics) was appointed the Director. After 9 months of Dr Ross Ashby's Directorship, the four senior staff tendered their resignations and eventually Dr Ross Ashby resigned (leaving to take up a Chair of Biophysics and Electrical Engineering at the University of Illinois, USA). The Institute was reorganised, a new Director (Dr Harry Crow who had worked at the hospital since 1956) was appointed and Dr Grey Walter became the Scientific Director. In 1962, the termination of the

Guinness grant led to the closure of the biochemical laboratory and the animal house. Financial stability remained difficult to achieve and on several occasions Dr Grey Walter was called upon to obtain funds at short notice; fortunately the Clement and Jessie V Stone Foundation of Chicago helped substantially, whenever asked on a transatlantic visit by Dr Grey Walter.

Patients with neuropsychiatric conditions, particularly epilepsy but also, (with an increasing interest in psychosurgery), patients with obsessive-compulsive and chronic neurotic disorders, were admitted and treated under the long-standing contract with the Regional Hospital Board. The Burden Neurological Institute was registered as a Mental Nursing Home. However, it became increasingly difficult for the clinical service to keep up with the rising standards of the NHS without spending a large amount of money. In 1968, after several years of discussion, the Burden Trustees sold the land and the buildings to the Minister of Health and the clinical services became the responsibility of the Cossham and Frenchay Hospital Management Committee. The clinical, nursing and ancillary staff became employees of the NHS. The clinical work continued much as before under the name of the Burden Neurological Hospital. However, it was not appropriate for the scientific research work to be part of the NHS, so a Company Limited by Guarantee was formed in 1970 so that the research work could carry on under the original name of the Burden Neurological Institute. Whilst the new Institute was being created, disaster struck, when Grey Walter was severely injured in a road accident. Dr Grey Walter fell from his motorcycle on his way into work, when trying to avoid a runaway horse. He sustained serious brain injury and, although he did subsequently manage to return to work, he was never able to produce the major scientific output which had been his hallmark before the time of the accident.

Scientific Work of the Institute

At its inception, in 1939, brain science was in a very primitive state. However, the dominant theme of the Institute and Hospital has always been to understand brain mechanisms and function, and to use that knowledge in order to help individual patients. This was Golla's vision for the Burden Neurological Institute, and one which he and his successors have always strived towards. During the first 20 years of the Institute, research was undertaken into neuroendocrinology (particularly Professor Reiss's work on the pituitary gland), the research into the effect of alcohol on rats was carried out by Mr MacLeod and Dr Goddard. However, the main research endeavour of the Burden Neurological Institute has always been into neurophysiology and the understanding of brain functioning, with occasional side-trips into such subjects as cybernetics and cerebral haemodynamics. Dr W Grey Walter (affectionately known all over the world as 'Grey') led the neurophysiological research. Grey Walter's own research had started with his discovery of very large slow fluctuations of EEG potential over tumours, following from work which he carried out in Golla's Central Pathological Laboratory, demonstrated the usefulness of the EEG as a diagnostic tool. Grey Walter went on, after moving to the Burden Neurological Institute, to discover the importance of the inter-ictal EEG in epilepsy, to describe the theta

(as well as the delta) rhythm of the EEG, to establish photic flash as a routine provocative technique in EEG recording and, indeed, to establish the EEG as a prime neurological and neuropsychiatric investigative method.

Grey Walter's enormous reputation resulted in a constant stream of national and international scientists through the Burden, while his charismatic personal style of teaching and lecturing also brought him to the attention of a very wide lay audience. He was a member of the original Brains Trust Panel on the BBC and one of the few scientists regularly regarded by 'the media' as being able to interpret brain research for the general population. His book *'The Living Brain'* played an important part in informing the general public about brain functioning, but also (along with his personal lecturing and visits to the Burden) encouraged many young doctors and scientists to develop an interest in the neurophysiological investigation of the brain. This was at a time when (as perhaps now) British neurology in general was not particularly interested in the brain, preferring to investigate peripheral neurological function. Grey Walter's famous cybernetic 'tortoises', were the first cybernetic robots to be designed and were able to carry out complex 'behavioural' patterns with the use of only two 'senses' (response to light and to touch). Grey Walter had always, also, been interested in the temporal relationships of EEG phenomena and developed a valve driven 'brain mapping' device (the toposcope) decades before the modern development of brain mapping. Along with Dr Ray Cooper and Dr Harry Crow and the neurosurgeon, Mr Dougie Phillips, Grey Walter and the team developed a method of implantation of gold electrodes which could be used not only for intracerebral recording, but also for multiple coagulation of white matter, a technique developed further by Dr Harry Crow into the multiple leucocoagulation method of psychosurgery in obsessive-compulsive disorder and grossly severe anxiety disorders. Towards the end of his working life, Grey Walter and the whole Burden Institute team became increasingly interested in the neurophysiological correlates of attention, and discovered the first brain measure of 'A state of mind'. They became aware of a slow rise in negativity as an individual was waiting for something to happen. They termed this the Contingent Negative Variation (CNV) and presented this important work in 1964, followed by a paper published in *Nature* in that year (Walter et al 1964). This created considerable interest in the CNV as well as various other similar slow brain potentials, which have developed into an important major area of neurophysiological research.

Thus, the Burden Neurological Institute developed an international reputation in the field of brain neurophysiology, and Grey Walter's centre was regarded as a Mecca for brain scientists from all over the world. Meanwhile, the clinical services continued, under the Directorship of Dr Harry Crow, with an interest in the neuropsychiatry of epilepsy, of chronic neurotic disorders, and of brain injury. The Burden Neurological Hospital was Britain's only neuropsychiatric hospital and, for 20 years, Dr Harry Crow was the only consultant neuropsychiatrist, specifically so-named, within the National Health Service. Grey Walter had set up the first clinical EEG department in the country (and possibly in the world) at the Burden Neurological Institute, and this clinical department continued actively under Dr Crow's supervision. The first electroconvulsive therapy (ECT) carried out in Great Britain was done at the Institute in 1939 under Golla's supervision and, with Fleming, Golla published the first British paper on this

subject (Fleming et al 1939). Golla also encouraged the investigation of the new procedures of psychosurgery, and Mr Willway carried out the first pre frontal leucotomy in this country in 1939 on one of Professor Golla's patients. With his assistant, Dr Hutton, Golla became particularly concerned about the change of personality which could accompany this operation and they published several warning papers on this topic. Later refinement of the technique, using the multifocal leucocoagulation procedure developed by Dr Harry Crow rekindled interest in psychosurgery and, with this most refined and selective form of psychosurgery, 163 patients were operated on during the 1960s and 1970s. The undesirable adverse effects which had brought the earlier form of psychosurgery into disrepute, were largely avoided and major benefits were obtained for the patients. Increasingly, the Burden Neurological Hospital became known as a centre for the careful assessment and appropriate management of epilepsy, and this remains an important and significant proportion of the clinical work of the hospital.

In 1935, 4 years before Golla set up the Burden Neurological Institute, he wrote in his Royal Society of Medicine address, 'I look forward to the day when a neurologist will be a humanist in the widest sense, when the psychiatrist will no longer shun the laboratory and the neurophysiologist will be a trusted collaborator of the psychologist'. This vision, often out of keeping with the great and sad division between neurology and psychiatry in this country, sustained the Burden Neurological Institute and Hospital through difficult times and proved to be of great heuristic value. In a more modern time, when all psychiatrists are realising that the brain has influence on behaviour and when more neurologists are beginning to realise that behaviour has influence on the brain, the interests and values of Golla and his Institute have shown themselves to be of lasting worth.

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25 Focal Sepsis and Psychosis: The Career of Thomas Chivers Graves, BSc, MD, FRCS, MRCVS (1883-1964)

ANDREW SCULL

Thomas Chivers Graves, like most of his contemporaries in the psychiatric profession, has now fallen into obscurity. For more than a quarter of a century, though, he was one of the major figures in British psychiatry, his standing among his peers being recognised by his election in 1940 as President of the Royal Medico-Psychological Association (RMPA). Because of the war, he was to continue in that office until November, 1944, making his tenure as its head the longest in the organisation's history. Of more direct moment from a practical point of view, his position as Chief Medical Officer to the Birmingham Mental Hospitals Committee (even as he simultaneously served as superintendent of two of them, Rubery Hill and Hollymoor Mental Hospitals) 'gave him supervisory powers over all the other mental hospitals controlled by the City of Birmingham'¹ and placed him in charge of many thousands of patients, thereby ensuring that his views on psychiatric therapeutics were implemented on a broad scale.

Graves was born on May 11, 1883, in Histon, Cambridgeshire. His father was a veterinary surgeon, and an itinerant preacher for the Plymouth Brethren.² Thomas absorbed his father's sectarian religious beliefs (including a lifelong and very passionate prejudice against Roman Catholics).³ At least initially, he also chose to follow in his father's footsteps when choosing his career. Educated at the Perse School in Cambridge, he proceeded from there to the Royal Veterinary College, from which he graduated in 1904, at the age of 21. Graves had proved an exceptionally talented and adept student, however, and his mentor, Professor Shave, whose assistant he now became, urged him to consider applying his talents to humans rather than animals.

Though related to the well-to-do Chivers family (whose wealth derived from its jams and preserves business), Thomas came from an impecunious household, and could not ordinarily have endured the additional expense of obtaining a medical qualification. His obvious abilities, however, allowed him to secure the Bucknill Scholarship at University College Hospital Medical School,⁴ and together with income from some part-time work as an anatomy demonstrator and from giving veterinary instruction in his spare time, these funds allowed him to complete his medical education. By any measure, his student career was a glittering one. Almost incidentally, he obtained a BSc in Anatomy & Physiology as he proceeded, and by the time he took his MB, BS with honours in Forensic Medicine and Hygiene in 1912, and qualified as MRCS and LRCP, he had won

gold medals in Anatomy, Physiology, Pharmacology, Hygiene, and Public Health, as well as the Liston Gold Medal in surgery.

Of all these sub-specialties, it was surgery to which he was most attracted, and in which he sought to make his name. After a period as house-surgeon to Bilton Pollard at University College Hospital, he secured an obstetric residency there, and in 1914, at the age of 31, became a Fellow of the Royal College of Surgeons. At once, however, his career plans, like those of all men of his generation, were interrupted by the outbreak of war. He promptly joined the Royal Army Medical Corps, and by the time he was demobilised at the end of the war, he had elected to abandon his previous plans, turning instead to psychiatry as the means to secure his livelihood.

There is every indication that this radical change of plans was primarily motivated by economics rather than any alteration in Graves' intellectual horizons. Building a surgical practice in London in this period was a drawn-out and uncertain business, and even the most talented could look forward to several years of fluctuating and inadequate income before success might materialise. By the end of the war, though, Graves was not only approaching 40, but he had acquired a wife, Evelyn Dorothy Lang, the daughter of a colonel and a member of Queen Alexandra's Royal Army Nursing Service. Under the circumstances, a surgical career must have seemed out of the question.

In turning from surgery to psychiatry, however, Graves was moving from one of the most to one of the least prestigious branches of medicine. To be sure, appointment as an asylum superintendent brought with it a measure of economic security, and a large measure of authority over the self-contained world over which one presided – some measure of compensation for the personal and professional sacrifice the career change cost him. Still, the choice was undoubtedly an unusual one, and both directly and indirectly, it probably reflected the influence of the war, not just on his personal circumstances, but in bringing him into sustained contact with psychiatric casualties. Perhaps the encounter with victims of shell-shock prompted him to take an intellectual interest in the problem of mental disorders (though, as we shall see, virtually from the outset of his asylum career, Graves sought to counter the distinction between mental and physical disease). Certainly, however, it was these wartime experiences that provided him with relevant experience on the basis of which he could plausibly become a candidate for an asylum post.

A glance at the status of psychiatry in the first decades of the new century serves to make clear the magnitude of the career change which a move into the mental hospital sector represented. As early as the 1880s, as advances in basic science began to have demonstrable relevance for the understanding and then the treatment of disease, leading psychiatrists had responded by publicly expressing anxiety about being left behind the rest of medicine. The profession, in W.T. Gairdner's words, saw itself as being at risk of becoming 'wholly divorced from the progress of medical science'⁵ – and such fears had proved to be well-founded. By 1911, the Medico-Psychological Association (M-PA), mindful of their increasing marginality and of the disparaging attitudes of their medical brethren, set up a committee under the chairmanship of Bedford Pierce, the superintendent of the York Retreat, to examine the status of the profession and to suggest ways of improving its standing. Both the committee's interim report, presented in 1913, and the final version brought to the Association's annual

meeting a year later, must have made sobering reading for the membership at large. 'The lunacy service', the committee acknowledged, existed in a twilight world 'divorced from ordinary medical education and practice' – and the committee found itself forced 'to consider what means could be devised to remedy the grave defects in the present position of psychiatry.'⁶

It was far easier, however, to enumerate the difficulties which confronted the profession than to suggest effective means with which to 'wipe out the reproach, at present attached to our specialty.'⁷ In the first place, 'Psychiatry as a branch of medicine is in a decidedly inferior position to practically every other branch in the lack of educational facilities, and in the absence of any career for those who desire to undertake scientific work in it.'⁸ At best, a third of those serving as assistant medical officers in asylums could aspire to obtain an asylum superintendency, even after decades of service, 'while short of this there are few attractive posts.'⁹ Isolation from the world at large was all but complete; 'in many asylums no organised research work is carried on, and clinical and pathological investigations are often ill-directed, haphazard, consequently fruitless'; in other respects, 'the work assigned to Junior Medical Officers is in the majority of cases monotonous, uninteresting, and without adequate responsibility [which] leads to the stunting of ambition and a gradual loss of interest in scientific medicine'; the routine and desultory qualities of asylum life tended 'to kill enthusiasm and destroy medical interests [as well as] to produce a deteriorating effect upon those who remain long in the service'; and in return for enduring such miserable working conditions, and serving at the sole whim and discretion of the asylum superintendent, most medical men in the specialty could look forward to salaries so pitifully inadequate as to force them to remain celibate (if, indeed – as was often the case – the regulations of the asylum itself did not directly forbid them to marry).¹⁰

These myriad disabilities and discouragements, together with the widespread perception that lunacy was a congenital and all-but-incurable condition, had predictable effects on the quantity and quality of the recruits to the profession. The war years, however, precipitated a still more serious crisis for psychiatry, since a veritable epidemic of disabling nervous breakdowns at the front brought into question the intellectual consensus that had developed within asylumdom about the aetiology of mental disorder, and cast grave doubt upon the practical value of its conventional therapeutics. Shell-shock, as it came to be known, became an ever more threatening problem as the war proceeded, accounting for as many as '40 per cent of the casualties from heavy fighting zones', afflicting the officer corps twice as often as the other ranks, and producing devastating effects on army morale.¹¹

As Martin Stone has noted, 'The psychiatric establishment lost a great deal of credibility over shell-shock.'¹² Not only was there an epidemic of 'a new war disease before which doctors seemed well nigh helpless',¹³ and in the face of which their therapeutics seemed especially useless; but of perhaps still greater moment, the status of its victims – the manly heroes who had volunteered for the front – made it all but impossible to assimilate these cases of mental disorder to the ubiquitous explanation pre-war psychiatry had proffered to account for the legions of chronically insane pauper lunatics – the notion that insanity was predominantly a symptom of hereditary degeneration.¹⁴ Marginalised as a source of ideas about aetiology or therapeutics, asylum doctors also found that in

practice, other branches of the medical profession – neurologists, but also general practitioners and even surgeons – were stepping into the breach and involving themselves in the treatment of the disorder.

Indeed, it is precisely in this context that Graves had his first contact with psychiatric patients. Joining the Royal Army Medical Corps at the outset of the war, he soon found himself working in a unit dealing with shell-shock cases,¹⁵ and as early as 1915, somewhat surprisingly (for he had shown no prior interest in psychiatry), he became a member of the Medico-Psychological Association. Though a sizeable minority of the medical men called upon to cope with the epidemic came to attribute the disorder to psychodynamic factors (and indeed some scholars have forcibly argued that shell-shock played an indispensable role in the emergence of psychodynamic psychiatry in Britain)¹⁶ such views remained ‘anathema’¹⁷ to most of their colleagues in the RAMC, who strongly preferred an organic explanation of shell-shock’s pathology. Here, at least, the army doctors were at one with what had long been the orthodox British psychiatric view of the origins of all varieties of mental disorder. Unfortunately, we have no direct knowledge of Graves’ position on the matter, but there seems little doubt, given his prior medical background and his subsequent views on the aetiology of mental disorder of all sorts, that his own sympathies must have lain with the somatic viewpoint.

At all events, by war’s end, Graves had decided to pursue a career in psychiatry, and on demobilisation, he promptly obtained qualification in Psychological and Nervous Diseases from the University of London, and equally rapidly secured the superintendency of the Hereford County Asylum. Less than a year later, he had moved to a more powerful and visible position, taking up on January 1, 1920 the post of Medical Superintendent of Rubery Hill and Hollymoor Hospitals in Birmingham, and by 1926, his empire had expanded still further, with his appointment as Chief Medical Officer to the City of Birmingham Mental Hospitals Committee. The retirement in 1926 of Cecil Roscrow, the superintendent of the third Birmingham mental hospital, made it possible to join all the hospitals together administratively as the City Mental Hospital. Graves’ authority was further strengthened when the Committee then proceeded to appoint Dr. Forsyth, who had served seven years as Graves’ Deputy Superintendent at Hollymoor, as the new superintendent at Winson Green.¹⁸

Despite the paucity of his prior experience in psychiatry, Graves’ stellar medical credentials coupled with his wartime clinical duties had enabled him to move into the psychiatric service at its highest levels, avoiding entirely the years of drudgery and subservience as an assistant medical officer which were ordinarily the precondition for a superintendency.¹⁹ He brought with him reservoirs of energy and enthusiasm, and ‘a determination to bring the study of pathology and the basic principles of medicine into the practice of psychiatry.’²⁰ And he entered upon a position in which he had, like other superintendents of the period, considerable latitude to implement his ideas and enthusiasms. If not quite the monarch of all he surveyed, a superintendent nonetheless possessed near autocratic powers over all aspects of the artificial closed community over which he presided; and Graves’ imposing physical stature (he stood over 6’ 1’ tall) and his domineering and charismatic personality²¹ allowed him to exercise his nominal authority to its full extent.

His early months at Rubery Hill were occupied with the task of retransforming

the institution back from the war hospital it had been to the mental hospital it was once again to become, and renovation and expansion of the physical plant were to occupy a substantial part of his time through the mid-1920s. The almost uninhabitable set of buildings he had inherited, bereft of any residents, had by early 1921 been refitted to house 560 patients, and by 1925, he had added new day rooms and a number of bungalow wards at both Hollymoor and Rubery Hill.²² A larger than life figure who possessed considerable talents as an administrator, Graves revelled in his position, dominating both his colleagues and his patients, and seizing opportunities to secure the spotlight, whether in lectures to fellow psychiatrists illustrated with copious slides and statistics; or in taking the leading role in asylum productions of Gilbert & Sullivan and annually in 'the part of Pooh-Ba at the hospitals' Christmas show, where the applause stopped the performance at several points.²³ [See Illustration near page 256] He even had the opportunity to play the gentleman-farmer: like most hospitals of its era, his had a farm attached, whose milk, butter, meat, and eggs were worth more than £7,500 in 1922. Indirectly, therefore, Graves' veterinary training was thus eminently useful on a regular basis.

It was, however, his background as a surgeon that was to place a more distinctive mark on his psychiatric practice during the next three decades. Though a psychodynamically-orientated psychiatry had made notable advances during and immediately after the war, and was rather less often the target of open hostility and intemperate criticism than it had once been, the long-standing disdain and distrust felt by the mainstream of the profession still lingered only barely beneath the surface.²⁴ Graves' refusal to place much stock in a 'childhood history of frustration' as the source of mental disorder²⁵ thus made him very much a part of mainstream professional opinion. In opposition to psychodynamic explanations, beginning in 1922 he was advancing, both in print and in person, a very different account of the sources of mental illness, one which from the outset found a sympathetic audience among leading figures in the medical profession at large, as well as among many of his fellow specialists.

First articulating his views in a short paper published in the *Lancet* in 1922,²⁶ Graves advanced with increasing aggressiveness the thesis that mental disorder was the product of auto-toxicity, caused in its turn by the presence in a variety of organs of chronic untreated reservoirs of infection. The hypothesis, as he was quick to acknowledge, was by no means a novel one. A more substantial paper delivered the following year to the M-PA's Annual Meeting in London opened with a quotation from Maudsley's *Physiology & Pathology of Mind*, written more than half a century earlier:

There is no want of evidence that organic morbid poisons bred in the organism or in the blood itself may act in the most baneful manner upon the supreme nervous centres. The earliest and mildest mental effect by which a perverted state of blood declares itself is not in the production of positive delusion or incoherence of thought, but in a modification of mental tone. The further effect is to engender a chronic delusion of some kind. A third effect of its more acute action is to produce more or less active delirium and general incoherence of thought.²⁷

Graves then proceeded to invoke a variety of authorities in support of his basic contention that 'clinically an important relationship can be demonstrated to

exist between prolonged emotional disturbance and chronic septic processes, occurring in hard tissues, especially in connection with the jaws.'²⁸

However odd these and later extensions of Graves' views may now seem, in the context of the times they were seen as anything but eccentric. The late nineteenth and early twentieth century was an era dominated by bacteriological models of disease. Though the medical profession had initially greeted the claims of Lister and Pasteur with scepticism and ridicule, its entrenched conservatism rapidly gave way in the face of the powerful practical advances that flowed from their work: gains in both aetiological understanding and in therapeutic efficacy. In surgery, antisepsis (and the routine employment of anaesthesia) prompted rapid advances in the technical capacities of surgeons, and equally striking therapeutic gains. For a variety of acute and life-threatening diseases, similarly remarkable breakthroughs occurred within a short time. Within a five-year period, the typhoid bacillus, the plasmodia parasites that cause malaria, the tubercle bacillus, cholera vibrio, and diphtheria bacillus were all identified in the laboratory, and with the development of antiserums for diphtheria and tetanus, the medical outlook seemed completely transformed. General medicine's prestige (and the prospects of its practitioners) soared, along with expectations that medical science would soon extend its dominion over yet wider realms of disease and debility.

Yet a number of chronic, debilitating disorders – and not just those that pre-occupied psychiatrists – remained frustratingly recalcitrant in the face of every attempt to unravel their secrets. Even effective palliative therapies were in short supply, while the aetiology of these diseases remained speculative at best. Succumbing to the temptation to extend the reach of the bacteriological paradigm, however, a number of leading medical men on both sides of the Atlantic turned to the notion of focal sepsis for an explanation, suggesting that such chronic diseases as arthritis, rheumatic fever, nephritis, and degenerative diseases of the arteries 'might be caused by bacteria disseminated through the lymph or blood-streams from a hidden primary focus of infection.'²⁹ In view of the wide currency and scientific respectability of these views among the medical and surgical elite in the first decades of the twentieth century,³⁰ both Graves' embrace of the idea of focal infection as a cause of mental disorder and his ability to secure a sympathetic hearing for his theories among his colleagues are anything but surprising.

Nor was he the first to suggest a connection between infection and mental illness. As early as 1900, the British surgeon, William Hunter, seeking to apply the principles of 'Listerism' to general medicine, had suggested a role for focal infection in the causation of a wide variety of diseases.³¹ Six years later, the Scottish psychiatrist, Lewis Bruce, extended the array of troubles rotting teeth could cause, implicating them in the causation of insanity,³² and similar suggestions began to surface in psychiatric circles in the United States at around the same time.³³

A year before Graves made his first presentation on focal sepsis to his colleagues in the M-PA, these and other adumbrations of the importance of bacterial poisoning of the brain in the genesis of mental disorder had been forcibly brought to their attention at their 1922 meeting in Edinburgh, by Chalmers Watson, physician at the Royal Infirmary.³⁴ In his own remarks on the subject, Watson had placed at least as much emphasis on 'excessive putrefaction

in the bowel' as on decay in the mouth, and had invoked the sainted Lister in urging his audience to recognise

the urgent need at the present time to all cases of mental disorder being studied by alienists more from the standpoint of the general physician, full use being made of the routine modern methods of investigation as carried out by physicians with a modern outlook and knowledge.³⁵

Few in his audience were likely to be more receptive to such an appeal than Graves, essentially an outsider to the psychiatric profession in any event, and someone whose own primary 'ambition was to bring the study of pathology and the basic principles of medicine [as he understood them] into the practice of psychiatry.'³⁶

In the event, Graves' own advocacy of the treatment of focal infection was far overshadowed at the Association's 1923 annual meeting by the performance of a visitor from across the Atlantic, a man with whom he would afterwards enjoy the closest professional relations, Henry Andrews Cotton.³⁷ For while Graves presented a handful of cases to illustrate his claim that 'clinically an important relationship can be demonstrated to exist between prolonged emotional disturbance and chronic septic processes occurring in hard tissues, especially in connection with the jaws'³⁸ (Graves, 'Chronic Sepsis,' 1923, 471), Cotton advanced a much more far reaching and revolutionary set of claims. From 1919 onwards, Cotton had been publishing a series of papers based on his work as superintendent at the Trenton State Hospital in New Jersey, in which he proclaimed with growing certainty to have found the key to understanding and treating mental disorders. His claims were the focus of increasing controversy in American psychiatric circles,³⁹ but here, given the chance to address a new and receptive audience, Cotton's self-confidence knew no bounds.

Flattering his listeners by first stressing the British origins of the doctrine of focal infection, he then launched upon a panegyric to the effects of mounting a full-blooded assault on its presence in the mentally ill, urging them to join in 'the fight against sepsis in medicine' and for 'antiseptic medicine' – a term he credited to William Hunter. Like Graves, he had begun by extracting infected teeth, but in his case the battle had soon extended to a variety of other fronts in what amounted to a thorough-going assault designed 'to literally 'clean up' our patients of all foci of chronic sepsis.'⁴⁰ Sinuses, tonsils, stomachs, gall bladders, colons, cervixes, and seminal vesicles, all these and more might be potential sites of silent chronic infections leaching toxins into the lymphatic system and the bloodstream and poisoning the brain; and any or all might require excision by the surgeon's knife.

Such ruthless pursuit and elimination of sepsis, however, was blessed with the happiest of outcomes: an increase in 'our recoveries in this group from 37 per cent to 85 per cent.'⁴¹ All of these efforts, Cotton insisted, were dependent upon the most recent scientific advances of modern medicine: gastric analyses and serology, bacteriological work and X-rays, serums and vaccines, and above all, the miracles of modern aseptic surgery – for only the surgeon's knife and the dentist's forceps could in the last analysis ensure successful 'detoxification.' His audience were perhaps made somewhat uncomfortable by the scorn he poured upon what had long been British psychiatry's preferred explanation of mental

disorder, defective heredity ('This doctrine was more or less fatalistic, and simply served as a cloak to hide our ignorance of other factors' and it 'has had the most unhappy result of stifling investigation, and retarding constructive work');⁴² but most found themselves nodding in agreement when he turned to a far more savage assault on psychoanalysis ('The extravagant claims made by its advocates are without foundation or justification. Freudism has proven to be a tremendous handicap to psychiatry').⁴³

Making the obligatory bow towards a multi-factorial origin of 'the so-called functional psychoses', Cotton insisted that instead

the most constant [cause], and, from the standpoint of treatment, the most important one, is the intra-cerebral, bio-chemical cellular disturbance arising from circulating toxins originating from chronic foci of infection. . . . Instead of considering the psychosis as a disease entity, it should be considered a *symptom*, and often a *terminal symptom* of a long-continued chronic sepsis or masked infection, the accumulating toxæmia of which acts directly or indirectly on the brain-cells.⁴⁴

Such findings were the more significant in that they applied to the overwhelming majority of patients who ended up in mental hospitals. Praising his British audience for not swallowing Kraepelin's classification *in toto*, Cotton truculently asserted that

as a result of our work, I do not believe there is any fundamental difference in the functional psychoses. The more we study our cases, we are forced to conclude that distinct disease entities in the functional group . . . do not exist. The aetiological factors are the same . . . [in] the whole so-called functional group, such as manic-depressive insanity, dementia præcox, paranoid condition, the psychoneuroses, etc.⁴⁵

The attentive listener would have heard Cotton confess to certain unfortunate side-effects that sadly were the inevitable accompaniment of this massive advance. There were, for example, the patients whose 'serious lesions of the colon' necessitated remedial action – amounting to 'about 20 per cent of the 'functional' group.' As with other kinds of sepsis, the only remedy in his view was 'elimination,' a term which here turned out to have an unfortunate double meaning:

In our early operations the caecum and ascending colon were resected only . . . Further examination of the unsuccessful cases proved that the splenic fixture and descending colon were also involved. Consequently, in the last two years total colectomy has been performed in practically every case. This operation was done in 133 cases, with 33 recoveries and 44 deaths. Partial resection at the right side was done in 148 cases, with 44 recoveries and 59 deaths.

- mortality statistics which, he explained, could be tolerated since they were 'largely due to the very poor physical condition of most of the patients.'⁴⁶

But it was the extraordinary therapeutic success that Cotton claimed, and the degree to which his approach seemed to call up the most 'scientific' features of modern medicine, that his audience chose to focus upon. A series of prominent figures took advantage of the discussion session which followed to lavish praise

on their American visitor. Chalmers Watson pronounced his work 'wholly admirable', while Sir Frederick Mott, the pathologist to the London County Council Mental Hospitals, offered extravagant praise for Cotton's accomplishments. And William Hunter, the surgeon to whom Cotton attributed the original hypothesis connecting mental illness and focal infection, declared they had just listened to 'one of the greatest accomplishments connected with the subject of mental disease' – an 'utterly sound' piece of scientific work that in the words of George Robertson, the President of the M-PA, 'should have served to draw members from the alluring and tempting pastures of psychogenesis back to the narrower, steeper, more rugged and arduous, yet straighter paths, of general medicine. [For after all,] here were results which no one could deny.'⁴⁷

In a separate editorial on 'Chronic Sepsis and Mental Disease,' the editors of the *Journal of Mental Science* complimented Cotton on his 'remarkable courage and tenacity' and expressed the hope that his work 'will herald the dawn of a brighter day for those afflicted with mental disease and for the practice of psychiatry.' Certainly, they added, 'the idea that there may be one basic morbid condition underlying all these psychoses will not come as a matter of surprise to many psychiatrists.' The prospects were simply revolutionary:

If, by eliminating chronic sepsis in cases of manic-depressive insanity, dementia praecox, paranoid conditions, the psychoneuroses, and toxic psychoses, between 80 and 90 per cent recover, what a jettisoning of cherished theories, beliefs, and writings there will be!

[If, indeed!] The editors recognised that the breakthrough, Dr. Cotton's kind gestures towards British antecedents notwithstanding, was essentially American, but thanks to Dr. Graves, 'a beginning has been made in Birmingham. It is now up to London and other great cities . . . not to lag behind.'⁴⁸

Graves certainly had no intention of leaving it to others to prove the truth of his contentions. Nor was he content, like some of his colleagues, simply to lament the fact that 'psychiatry has failed to keep pace with progress to the same extent as other branches of medicine' or to bemoan a fate which left the specialty in 'regrettable isolation . . . occupying a position in relation to medicine as a whole analogous to that of a certified patient to the life of the community.'⁴⁹ Encouraged by the reception accorded to his and Cotton's ideas, he moved promptly and aggressively to implement a broader assault on focal sepsis than had previously been possible. A visiting gynaecologist and ear, nose, and throat (ENT) specialist were added to the hospital staff (a full-time dentist, Yaxall, had already been appointed); and Neville Chamberlain, MP arrived to open a newly established research laboratory at Hollymoor, before the year's end. By 1926, Graves had at his disposal a whole new set of buildings at Rubery Hill to which patients could be brought for the most advanced forms of treatment: operating theatres, as well as rooms for hydrotherapy, ultraviolet light treatment, and colonic lavage. With a full-time pathologist (F.A. Pickworth),⁵⁰ bacteriological laboratories, X-ray facilities, etc. he could boast that he had moved decisively to break down the barriers between psychiatry and general medicine, and to introduce the latest scientific advances into the treatment of mental disorder.

The following July, Graves received a visit at Rubery Hill from Henry Cotton, who was *en route* to the joint meeting of the British Medical Association and the RMPA (as it had become in 1926) in Edinburgh, and took the occasion

to compare notes. Cotton's extravagant claims of therapeutic success had in the interim prompted his hospital managers to sponsor an external review of his work, a report they intended to use to document his successes, but one whose findings in the event threatened to discredit his whole approach, and with it the general enthusiasm for the focal sepsis theory. He seems, however, to have given no hint of his troubles to Graves, let alone to the profession at large when he addressed them a few weeks later, and when his mentor, Adolf Meyer, suppressed the negative findings, the crisis passed and Cotton's work could continue unchecked.⁵¹

Unquestionably, though, Cotton was relieved to find himself in more sympathetic surroundings and in the company of another true believer. At Birmingham, he discovered that Graves had developed the treatment of focal sepsis in a number of directions that had not yet occurred to him: injections with anti-typhoid vaccine, for instance ('It produces a chill and a sharp rise in temperature, 103 to 105, which in an hour subsides . . . The results were remarkably satisfactory'); and a superior method for diagnosing and treating sinus infections ('pushing a cannula through the nose, puncturing the sinus, withdrawing the contents, and actually seeing the pus').⁵² On another front, 'The treatment was rather similar to ours as far as teeth and tonsils were concerned [though] it was rather astonishing to see them extract teeth without any local or general anesthetic . . . the patients did not seem to object to this method of extraction.'⁵³

From Birmingham, the two men travelled north together to Edinburgh, where they took starring roles together at the joint meeting of the RMPA and the mental diseases section of the BMA, virtually all of which was devoted to a series of papers promoting the idea of focal infection as the common cause in the functional psychoses – a constellation of diseases William Hunter (1927) suggested should now be renamed 'septic psychoses.'⁵⁴ Graves himself spoke forcibly about 'the possibilities of thorough disinfection';⁵⁵ and Cotton once more reviewed his astonishing achievements at Trenton, modestly adding in the informal discussion that followed that 'The work at Birmingham under Dr. Graves went beyond anything that had been done in the United States.'⁵⁶ Both men then basked in the praise of the assembled luminaries, with Sir Berkeley Moynihan, the incumbent President of the Royal College of Surgeons, providing a particularly lengthy and fulsome endorsement of their work. Emphasising the pioneering role of his fellow-surgeon, William Hunter in demonstrating 'the part played by slight and continuously overlooked forms of sepsis in causing distant and apparently unconnected disorders' (it was 'the most illuminating thing that had happened in medicine in the twentieth century [and] of the truth of his teaching there is not the slightest doubt'), Sir Berkeley concluded his speech with a bow towards the two alienists:

The work of Cotton . . . in New York, . . . and of Graves in this country seems to set us a new standard of inquiry in this branch of medicine, and to show that no mental hospital will in future be considered as adequately equipped unless it has an x-ray laboratory, a skilled bacteriologist, and can command the services of an enlightened surgeon.⁵⁷

Only D.K. Henderson, superintendent of the Gartnavel Royal Hospital in Glasgow, ventured any serious dissent from the prevailing atmosphere of mutual

self-congratulation. His attempt to draw attention to the work of some of Cotton's American critics, Kopeloff and Kirby, was roundly dismissed by William Hunter (the Americans had failed because they had made only token efforts to remove the sources of sepsis, generally extracting only a handful of teeth at a time; and besides 'Kopeloff was not even a doctor; he was a bacteriologist. He did not think psychiatrists need worry about Kopeloff's work').⁵⁸ And Henderson's objection that 'it was a great mistake to lay down dogmatic generalisations regarding cures founded on an individual case,' coupled with a suggestion that 'the cure of the woman cited by Dr. Hunter who had eleven bad teeth extracted might be due to the building up of her strength during two years in the hospital ward' was greeted by derisive laughter.⁵⁹

Graves, as it happens, characteristically adopted precisely the style of reasoning Henderson complained about in his reports on the successes associated with his work,⁶⁰ and was convinced beyond any shadow of a doubt that his clinical experience was sufficient to prove the validity of his theory. In demonstrating the value of his treatment methods, he routinely added sections to his papers illustrating a variety of cases 'cured' as a result of his interventions. He also showed how, where the disease proved resistant to one or another means of 'detoxication,' it could be overcome by yet further interventions directed at 'daughter infections' or designed to stimulate the body's defenses on a more global level. Henderson's appeal for controlled studies, with patients 'divided into two groups as nearly identical as possible . . . one group . . . treated surgically, while the other group had no surgical treatment'⁶¹ evidently fell on deaf ears so far as Graves was concerned.

At the Edinburgh conference, Henry Cotton had announced (not entirely accurately) that 'he no longer recommended colectomy, but used copious colonic douches instead', and added that 'the results of this irrigation in 600 cases had been very satisfactory.'⁶² Following Cotton's return to Trenton in 1927, Graves wrote for advice about this new approach, and subsequently devised an elaborate new apparatus of his own to permit 'continuous colonic irrigation', with different solutions used to wash out the bowel and treat 'intestinal toxæmia' – a technological breakthrough he subsequently shared with his colleagues.⁶³ Nasal washouts became an equally routine part of the therapeutic regime, as the sinuses came to be seen as a site of dangerous infections rivalled only by the teeth and gums. Meanwhile, alongside surgical intervention to drain or eliminate sources of infection, simultaneous efforts were made 'to stimulate a focal reaction' of the body's own defenses through what was termed 'non-specific therapy': injections of colloidal calcium oleate, of colloidal sulphur, or T.A.B. – with the latter often inducing nausea and fever, reactions Graves saw as 'an indicator of the activity of the agent' as well as a measure of 'the severity of the general toxæmia.'⁶⁴

The death of Graves' first wife in 1932 was followed a year later by his marriage to one of his assistant doctors at Rubery Hill, Kathleen Sykes, an anaesthetist-turned-psychiatrist. Sykes' published account of the hospital routine makes clear what a newly admitted patient could look forward to in these years. First, all new patients would be confined to bed for a week or more, rest being obviously essential to gathering one's internal resources for the fight against infection. A complete physical examination and a series of blood tests followed, and then the visiting specialists were mobilised: 'dental

and ear, nose and throat . . . gynaecologist . . . ophthalmologist [and] the X-ray Department.' All of this activity allowed the formation of a rational and individualised treatment plan. Active therapeutic efforts generally began with attention to the teeth, whose extraction permitted 'an obvious source of infection [to be] removed with little shock to the patient.' Further bed rest was generally followed by operations by the ENT specialist to remove the tonsils and explore the state of the sinuses while the patient was under general anaesthetic. After a further period of bed rest to recuperate, next there was an attempt at 'stimulating his resistance with some form of non-specific therapy' (injections of colloidal sulphur or Burroughs Wellcome's T.A.B. vaccine), interventions aimed at inducing 'a pyrexial response of between 103 and 105.' Meanwhile, the 'large proportion of female patients . . . found to have uterine endocervitis' could expect treatment by 'cauterization followed by antiseptic douches.' Male and female alike, if they were among the 'many patients found to have infected colons,' were then taken into special treatment rooms where 'muco-pus or pus in quantities is washed away and the condition greatly improved by a course of continuous colonic lavage administered on one of the special tables in use here.' Now 'relieved of their sources of gross toxæmia', the convalescing finished up with 'a course of ultra-violet light treatment.'⁶⁵

Though Graves was to remain a forcible advocate for the position that 'psychotics are physically infirm' and that there existed 'a common cause for the mental and physical illness',⁶⁶ it is not clear how many converts he managed to win and retain for his views among his psychiatric colleagues. At the outset, as we have seen, a number of leading figures, not just in psychiatry but in general medicine and in surgery, were enthusiastic converts to the focal sepsis hypothesis. Wagner Jauregg's discovery of the malarial treatment for general paresis had both stimulated a certain degree of therapeutic optimism, and had brought renewed attention to the realm of somatic treatments. With little else of comparable promise or appeal on offer, with extraordinary results reported from its practical implementation in the United States, and presenting an aetiological account of insanity that corresponded to the dominant contemporary model of disease and was linked rationally in its turn to a set of straightforward therapeutic interventions, the doctrine of focal sepsis had some obvious attractions. For psychiatrists, such an explanation of mental illness offered a way back into the medical mainstream, and since the treatment of focal sepsis required the use of the most advanced forms of medical technology as well as the services of a variety of medical specialists (surgeons, gynaecologists, oto-larynologists, and pathologists, not to mention dentists) it was likely to appeal to a broader medical constituency as well. Even patients and their families, desperate for some glimmer of hope and anxious to distance themselves from the stigma that had hitherto attached itself to mental disorder, were likely to find an explanation of their troubles couched in such familiar terms almost irresistible.

Who, after all, could argue against the need to eradicate infection? The most sceptical of Graves' and Cotton's claims – Henderson in the United Kingdom, Kopeloff and Kirby in the United States – were nonetheless hard-put to assert that the physical ailments now targeted for attack could be safely left untreated, inhibiting the force of at least some of their criticism.⁶⁷ Disinfecting the body, washing out or excising pus, infection, and decay – these were approaches and a terminology with a powerful appeal, symbolic and otherwise, to both professional

and lay audiences. Nor, particularly among working-class patients, was there any shortage of troublesome chronic infections in evident need of treatment: malnutrition (an increasing problem in these years of growing unemployment), inadequate (or non-existent) medical care, and poor (and often infected) teeth were endemic problems among the lower orders, providing a demonstrable array of somatic pathologies to which attention could be directed once patients were admitted to the mental hospital.

Even in the 1920s and early 1930s, however, Graves hardly won everyone over to his cause, and many who voiced some degree of support were nonetheless some considerable distance from fully embracing his approach. In the immediate vicinity, both Rampton Hospital and the Worcester County Mental Hospital at Powick⁶⁸ enthusiastically adopted Graves' techniques, and other evidence suggests his ideas were being implemented at the Chester County Mental Hospital, at the East Sussex County Mental Hospital, at the Cardiff City Mental Hospital, and at the Hallam Hospital in Sheffield.⁶⁹ The unprecedented turnout when the Northern and Midland Division of the RMPA held its autumn 1932 meeting at Rubery Hill likewise indicates at the very least a high degree of interest in Graves' ideas.⁷⁰

Whether because he was more honest or less deluded than Cotton, however, or perhaps because of the relatively strict oversight exercised by the Board of Control, Graves never laid claim to the kinds of extraordinary cure rates his American counterpart insisted he had achieved. Since vague claims that 'His figures for discharges proved that his methods were more successful than those generally employed in other mental hospitals'⁷¹ were scarcely borne out in the statistics appearing in the hospitals' annual reports, spectacular therapeutic success could not be invoked to convert the doubtful. As for other means of winning converts, the very force of Graves' personality could repel as well as attract, and his insistence that focal sepsis was *the* common cause of the functional insanities scarcely endeared him to his more eclectic colleagues. More seriously still, published reports began to cast doubt on just how widespread sepsis was among the mentally ill, to query whether the rate of focal infection differed as between the sane and the insane, and to call into question the methods Graves and his colleagues used to assess the presence of focal sepsis.⁷² When coupled with spreading doubts about the therapeutic efficacy of such measures as sinus irrigation, autogenous vaccines, etc. these developments gradually weakened his influence on the profession.

The appeal of the doctrine of focal sepsis to most psychiatrists suffered a further series of blows in the late 1930s and early 1940s, as a number of other somatic treatments, generally resting upon a very different logic, came to the fore. At the time such innovations as insulin coma therapy, cardiazol, and electrically induced convulsions (the only treatment of this sort still in widespread use today), together with various forms of leucotomy, were widely hailed, and represented an obvious rival for the profession's intellectual loyalties. Though inclined to experiment with insulin (and subsequently in a more limited way with cardiazol), as still another method of stimulating the body's own defences,⁷³ Graves was sharply critical of alternative somatic approaches, even as other psychiatrists hastened to adopt them.⁷⁴

Graves' marginalisation in his own profession grew more marked as his own views became more and more eccentric.⁷⁵ Ironically, this process must have

accelerated once he was elected President of the RMPA (a development that owed much to the outbreak of World War Two, and the departure into military psychiatry of men who might otherwise have been his rivals for the honour). [See Illustration 2] His 'Presidential Address,' issued under the long-winded title of 'Diphasic Vascular Variation in the Treatment of Mental Inefficiency Arising From a Common Somatic Cause,'⁷⁶ reiterated his prior views about focal sepsis with a new and peculiar twist, couched in prose which verged upon (and at times lapsed into) incoherence.⁷⁷ Graves now insisted that sepsis could be either 'open' or 'closed' (i.e., draining or encapsulated), requiring different therapeutic responses and imposing different risks on the organism. Therapies which increased vascularity in the presence of open sepsis would allow more toxins to be expelled from the body, thus promoting healing, but increased vascularity in the presence of closed lesions would have counter-productive effects, promoting the production and absorption of the poisons thrown off by the hidden focal infections. Quite explicitly, he invoked a homeostatic vision of the bodily economy deriving from Hippocrates, and, arguing that 'an abscess, an excretory disease if its discharges are drainable, can be an excellent development', drew the parallel with 'the use in the past of setons and blisters in order to induce what was hoped would be such excretory conditions.'⁷⁸

The following year, he organised a symposium for the one hundredth meeting of the RMPA, held in London on July 17, 1941. Significantly, while a whole series of ENT specialists⁷⁹ appeared to testify to the crucial significance of sinusitis in the genesis of mental disorder, only his long-time supporter H.F. Fenton of Worcester joined Graves in wholeheartedly endorsing their claims. Several psychiatrists, indeed, voiced the heretical view that 'in most of these cases one was not dealing with sinus infection as a cause of mental disorder at all. What was being done . . . was to introduce a very radical method of suggestion into the minds of patients and it was not remarkable if they showed the same "improvement" as was apparently to be found in all the recently introduced "successful" treatments of schizophrenia.' Since 'medicine in general had rather abandoned focal sepsis,' it was surely 'rather a pity' for their President to insist that 'they should have to examine all their patients for nasal sepsis,' particularly when their own 'ear, nose, and throat surgeons told them it was not as common as all that.'⁸⁰

Graves would have none of such scepticism. He insisted that 'he was quite satisfied that the essential point was to get at the portal of entrance.'⁸¹ With the outbreak of the war, Hollymoor had been transformed into a military hospital, with its existing patients redistributed to the other mental hospitals in the Birmingham region and Graves installed as its commandant (alongside his continuing role as superintendent at Rubery Hill). Many of the soldiers now arriving for treatment had suffered head injuries, and, given Graves' convictions, these patients, too, soon found themselves being treated vigorously and thoroughly for hidden foci of infection.⁸²

One of the most remarkable therapeutic changes of the era, of course, was the advent of penicillin, which opened up new vistas for the assault on bacterial infections. By the closing year of the war, Graves had recognised the significance of the new antibiotic and was anxious to incorporate it into his treatment of sepsis. Supplies, however, remained short, and the authorities proved reluctant to divert some of the precious drug to a mental hospital. Accordingly, Graves

began culturing his own crude 'penicillin filtrate' in jam jars all over the hospital, giving the resulting solution orally.⁸³ Subsequently, when he obtained 'a small supply of 'pure' penicillin' it was 'given to a few cases by intramuscular injection', with what Graves reported were uniformly favourable results.⁸⁴ By this time, however, the doctrine of focal infection had lost whatever credibility it had once possessed, and his psychiatric colleagues appear to have greeted his assertions with indifference.⁸⁵

Still supported by the Birmingham Mental Hospitals Committee, and aided by the uncertainties attending the end of the war, Graves nonetheless continued as superintendent at Rubery Hill & Hollymoor until 1948, and with the advent of the National Health Service, he was retained as a consultant psychiatrist until his retirement in 1950. Convinced till the end of the correctness of his own theories, he planned to devote his retirement to writing up his case materials and to producing a monograph which would decisively demonstrate the crucial importance of treating focal sepsis. But the world was now passing him by. With the advent of the psychopharmaceutical era in the mid-1950s, the biological treatment of mental disorder, for which he had tirelessly campaigned, acquired a wholly new focus and meaning. Publishers displayed no interest in the results of his labours, and as his own mental condition deteriorated, he laboured endlessly over his elephantine manuscript (now grown to several thousand pages, much of it scribbled on the backs of old envelopes).⁸⁶

In the end, Graves' declining condition led to his admission into a nursing home. Here, on June 6, 1964, aged 81, his life came to a close. He was buried in the grounds of the Baptist chapel at Histon, what began as a promising career having come to what must have been a bitter and depressing conclusion.

Notes

- 1 'Obituary Notice,' *British Medical Journal*, i, 1964, 1711.
- 2 Interview with Dr. Valerie Graves, July 28, 1986.
- 3 Interview with Dr. Frederick Graves, July 31, 1986. The younger Graves was virtually disowned by his father when he had the presumption to marry an Irish Catholic nurse during the Second World War. How these prejudices may subsequently have affected T.C.'s actions as head of mental hospitals which contained large numbers of Irish Catholics we simply do not know.
- 4 Though Graves at this time had no interest in a psychiatric career, the scholarship he now depended upon had been endowed, coincidentally, by the eminent nineteenth century alienist, Sir John Charles Bucknill (founding editor of the *Journal of Mental Science* and, in the 1880s, one of the four co-editors of *Brain*). Himself a graduate of University College, Bucknill had left one-third of his residuary estate in trust to its President and Council in his will in 1897, to establish 'a Medical Scholarship . . . to be awarded at least once in three years as the President and Council may from time to time decide.'
- 5 W.T. Gairdner, 'Presidential Address,' *Journal of Mental Science*, 28, 1882, 321-32; for similar sentiments, cf. Herbert Hayes Newington, 'Presidential Address,' *Journal of Mental Science*, 35, 1889, 293-315.
- 6 'Report of the Committee re Status of British Psychiatry and of Medical Officers,' *Journal of Mental Science*, 60, 1914, 667-9.
- 7 Ibid, 675. Indeed, the Committee's proposed remedies for the problems it had uncovered were extraordinarily threadbare. Appeals to the superintendents to modify the restrictive regulations which made the lives of their junior officers so unattractive and, most particularly, to permit their subordinates to marry, met with resistance and ridicule: as

- one superintendent commented, 'Marriage meant to a medical officer, a diminution of his value to the service for a time; in some it amounted to an observable post-nuptial inertia or dementia, a condition whose course was about twelve months. 700 a year would have a tendency, he feared, to make this condition chronic.' *Journal of Mental Science*, **12**, 1914, 689. As for the committee's other major proposal, the establishment on the German model of university-affiliated clinics for outpatient treatment and research on mental disorder, there was widespread and well-warranted scepticism about whether the necessary funds would be forthcoming from either local or central coffers.
- 8 Ibid, 670.
 - 9 Ibid, 671.
 - 10 Ibid, 667-94; cf. also 'Interim Report,' *Journal of Mental Science*, **59**, 1913, 688-706.
 - 11 Martin Stone, 'Shellshock and the Psychologists,' in W.F. Bynum, R. Porter, & M. Shepherd (eds), *The Anatomy of Madness Volume II*, London: Tavistock, 1985, p. 249.
 - 12 Ibid, 245.
 - 13 J.J. Mitchell & G.M. Smith, *History of the Great War Medical Services*, Volume 2. London: HMSO, 1930, p. 9.
 - 14 Not that a few psychiatrists didn't make the attempt. See, for example, Sir Robert Armstrong Jones' attempt to blame the outbreak on 'tainted heredity' (*Nature*, **100**, September 6, 1917, 1-3) – a stance which was unlikely to sit well with either the politicians or the public, and which opened him up to the devastating riposte that he was committing 'a slur upon the noblest of our race.' G.E. Smith and T.H. Pear, *Nature*, **100**, September 27, 1917, 65.
 - 15 Interview with Dr. Frederick Chivers Graves, July 31, 1986.
 - 16 Cf. M. Stone, op. cit., 1985; Elaine Showalter, *The Female Malady*, New York: Pantheon, 1985, Chapter 7.
 - 17 Millais Culpin, *Recent Advances in the Study of the Psychoneuroses*, London: Churchill, 1931, p. 24.
 - 18 A.H. Ogden, 'T.C. Graves and Focal Sepsis Theory,' unpublished paper delivered at the Regional Meeting of the Midlands Division of the Royal College of Psychiatrists, 1983, p. 5. (I am very grateful to Dr. Ogden for sharing this most helpful survey with me, and I have drawn upon his lecture at a number of points in this essay. Through his kindness, I was also able to inspect the operating theatre and other facilities at Rubery Hill in June 1987, as well as to talk with a number of former members of staff who had worked under T.C. Graves.)
 - 19 The appointment of an outsider to such a post must obviously have come as a bitter blow to aspiring assistant physicians. Three such doctors had once ruefully compared their situation with that of 'dutiful relatives, most patiently await[ing] the falling in of their estate.' They felt that the contrast of 'the fat salaries of the Superintendents with the lean ones of the assistants' had perhaps been bearable 'when the Assistant Medical Officers were few and superintendencies ripened in four or five years, but [their elders' counsel to be patient] loses all its sweet reasonableness when we have to wait ten, twelve, or more years for the golden fruit, and even run the risk [they prophetically added] of its being plucked by some outsider from over the wall just as we thought it about to drop.' Dr. Dodds, Dr. Strahan, and Dr. Greenlees, 'Assistant Medical Officers in Asylums: Their Status in the Specialty,' *Journal of Mental Science*, **36**, 1890, 43-50.
 - 20 'Obituary,' *British Medical Journal*, **i**, 1964, 1711.
 - 21 His obituarists discreetly termed him 'stimulating, but at times overwhelming.' (*British Medical Journal*, **i**, 1964, 1711.) His daughter-in-law more bluntly informed me that he was 'a bit of a bully,' and Dr. D.W. Millard (personal communication), who became consultant psychiatrist at Rubery a few years after Graves' retirement found that 'T.C. seemed to have been capable of inducing real terror among the staff' – a reaction Millard attributes to the 'fact that he was an absolute tyrant.'
 - 22 A.H. Ogden, op. cit., 1983, p. 3.
 - 23 'Obituary,' *British Medical Journal*, **i**, 1964, 1711; interview with Dr. Valerie Graves, August 28, 1986; A. Ogden, op.cit., 1983, p. 4.
 - 24 On the sources and extent of this hostility, cf. Michael Clark, 'The Rejection of Psychological Approaches to Mental Disorder,' in A. Scull (ed.), *Madhouses, Mad-Doctors, & Madmen: The Social History of Psychiatry in the Victorian Era*. Philadelphia: University of Pennsylvania Press, 1981, pp. 71-101; and Malcolm Pines, 'The Development of the Psychodynamic Movement,' in G.E. Berrios & H. Freeman (eds), *150 Years of British Psychiatry 1841-1991*, London: Gaskell, 1991, pp. 206-31.
 - 25 'Obituary,' *The Lancet*, **i**, June 20, 1964, 1400.
 - 26 T.C. Graves, 'Colloidal Calcium in Malnutrition, Chronic Sepsis, and Emotional Disturbance,' *The Lancet*, **ii**, 1922, 957.

- 27 Quoted in T.C. Graves, 'The Relation of Chronic Sepsis to So-called Functional Mental Disorder,' *Journal of Mental Science*, **69**, 1923, 465.
- 28 *Ibid.*, 471.
- 29 Franklin Billings, *Focal Infection*. New York: Appleton, 1916. (Billings was dean of the Rush Medical School in Chicago, and past president of both the American Medical Association and the American Association of Physicians. This book was his Lane Lectures, delivered at Stanford Medical School in 1915.) See also idem, 'Focal Infection: Its Broader Application in the Etiology of General Disease,' *Journal of the American Medical Association*, **63**, 1914, pp. 899-903; Lewellys F. Barker, 'Oral Sepsis and Internal Medicine,' *Journal of Dental Research*, **2**, 1920, 43-58. Leading American physicians who embraced focal infection included Edward Rosenow and Charles Mayo of Minnesota, and William Thayer and Llewellys Barker at Johns Hopkins. British adherents included Sir William Wilcox, Sir Arbuthnot Lane, William Hunter, and Chalmers Watson.
- 30 For some chronic diseases whose aetiology remained poorly understood, focal sepsis continued to be suspected as the culprit even into the 1950s.
- 31 W. Hunter, 'Oral Sepsis as a Cause of Disease,' *British Medical Journal*, **ii**, 1900, 215-16 – views reiterated at greater length in later papers, where he was to make a particular point of its role in the genesis of 'dementia praecox, manic depressive insanity, paranoid conditions, psychoneurosis, and toxic insanities.' 'Chronic Sepsis as a Cause of Mental Disorder,' *Journal of Mental Science*, **73**, 1927, 549-63; 'The Relation of Focal Infection to Mental Diseases,' *Journal of Mental Science*, **75**, 1929, 464-6.
- 32 Lewis Bruce, *Studies in Clinical Psychiatry*, London: Macmillan, 1906. In his Morison Lectures two years later, Bruce was still more emphatic, and had widened the potential source of trouble: 'There are . . . many links in the chain of evidence wanting, but such evidence as is already in my possession is sufficient to warrant the general conclusion being drawn that the disease known as mania is due to bacterial toxæmia, which is in many ways comparable to the bacterial toxæmia of rheumatism.'
- 33 H. Upson, 'Nervous Disorders Due to the Teeth: A Preliminary Report,' *Cleveland Medical Journal*, **6**, 1907, 458-9; idem, 'Dementia Praecox Caused by Dental Impaction,' *Monthly Cyclopaedia & Medical Bulletin*, 1909, 648-51; idem, 'Serious Mental Disturbances Caused by Painless Dental Lesions,' *American Quarterly of Roentgenology*, **11**, 1910, 223-43.
- 34 Chalmers Watson, 'The Role of Auto-Intoxication or Auto-Infection in Mental Disorders,' *Journal of Mental Science*, **69**, 1923, 52-77.
- 35 *Ibid.*, 63, 75.
- 36 'Obituary,' *British Medical Journal*, **i**, 1924, 1711.
- 37 For an earlier account of Cotton's work, on which I have drawn in what follows, see Andrew Scull, 'Desperate Remedies: A Gothic Tale of Madness and Modern Medicine,' *Psychological Medicine*, **17**, 1987, 561-77.
- 38 *Ibid.*, 471.
- 39 See especially 'Discussion – Functional Psychosis,' *American Journal of Psychiatry*, **79**, 1922, 195-210.
- 40 Henry A. Cotton, 'The Relationship of Chronic Sepsis to the So-Called Functional Mental Disorders,' *Journal of Mental Science*, **69**, 1923, 434-65.
- 41 *Ibid.*, 438. Later in his paper, Cotton contrasted the recovery rate at Trenton between 1908 and 1918 (38 per cent), with the rate between 1918 and 1922, which corresponded to the implementation of a radical programme of eliminating sepsis (87 per cent, or 'a total of 1,412 successfully treated cases'). *Ibid.*, 458-9.
- 42 *Ibid.*, 439. Elsewhere, he had claimed that 'Modern biological research tends to show that the inheritance of mental disorders . . . is next to impossible.' H. Cotton, 'The Etiology and Treatment of the So-Called Functional Psychoses,' *American Journal of Psychiatry*, **79**, 1922, 158.
- 43 *Ibid.*, 440.
- 44 *Ibid.*, 443, 444.
- 45 *Ibid.*, 444-5.
- 46 *Ibid.*, 454, 457.
- 47 *Journal of Mental Science*, **69**, 1923, 553-8.
- 48 'Chronic Sepsis and Mental Disease,' *Journal of Mental Science*, **69**, 1923, 502-4.
- 49 Henry Devine, 'Presidential Address on Psychiatry and Medicine,' *British Medical Journal*, **ii**, December 6, 1924, 1033.
- 50 For his contributions, see F.A. Pickworth, *Chronic Nasal Sinusitis & Its Relation to Mental Disorder*, London: Lewis, 1935; idem, *A New Outlook on Mental Disease*, Bristol: Wright, 1952. I am grateful to Dr. John Pickworth for information on his father's work at Rubery Hill.

- 51 The study had been undertaken over an 18-month period by one of Meyer's assistants, Phyllis Greenacre. Her work had meticulously documented the spurious character of Cotton's claims, demonstrating, for example, that the death rate from his abdominal surgery approached 43%, and that the more extensive the treatment a patient received for focal sepsis, the lower his or her chance of recovery. For details of this episode, and Meyer's unsavory role in covering up a major medical scandal, see Scull 1987.
- 52 This is still the routine procedure when treating difficult sinus infections.
- 53 Henry A. Cotton, 'European Rambles of a Psychiatrist,' unpublished typescript, Trenton State Hospital Archives, Trenton, New Jersey, 1927. Dr. Millard (personal communication, see note 21) confirms that stories of Graves extracting teeth sans anaesthetic were still circulating in hospital mythology in the 1950s, and suggests, not implausibly, that sporadic instances of recovery following this procedure may have followed upon cases of toxic confusion being mistaken for psychosis – raising 'the possibility of occasional misdiagnosis . . . conferring enough spurious credibility to help [sustain belief in the focal infection hypothesis].'
- 54 Hunter's work was hailed in the *Times* (July 21, 1927) as the 'work of a new Lister.' It approvingly quoted his dictum that 'All the public authorities responsible for the mental hospitals should issue an order that every mental hospital under their charge should . . . be forthwith supplied with every arrangement for surgical work' while warning its readers of the dangers of sepsis, whose 'foci were small, hidden, chronic, and generally caused no local effect drawing attention to themselves.'
- 55 'Discussion: Chronic Sepsis as a Cause of Mental Disorder,' *British Medical Journal*, bii, November 5, 1927, 817.
- 56 Ibid.
- 57 Sir Berkeley Moynihan, 'Relation of Aberrant Mental States to Organic Disease,' *British Medical Journal*, ii, November 5, 1927, 815, 817. The *Daily Telegraph's* report of the occasion (July 21, 1927) indicates that these encomiums were greeted with 'loud cheers.' Further symbolising the endorsement of focal sepsis theory by the Establishment, during the meeting Moynihan and Hunter were recognised for their contributions to its triumph by the award of honorary Doctorates of Law from Edinburgh University.
- 58 *Journal of Mental Science*, 73, 1927, 726; W. Hunter, 'The Relation of Focal Infection to Mental Disease,' *Journal of Mental Science*, 75, 1929, 464-6.
- 59 *Daily Telegraph*, July 21, 1927. The following day, the *Telegraph* left no doubt where its sympathies lay in the debate. In an editorial on 'Mind and Body,' it hailed 'a new and hopeful vista in the prevention, amelioration, and cure of mental disorders.' 'It is not,' the leader pointed out, 'the layman who will find any difficulty in accepting as reasonable the conclusions presented by Dr. William Hunter . . . The effect of septic poison coming from diseased teeth or from pockets of infection at their roots is by this time thoroughly well known. All sorts of bodily ailments are now attributed to this cause, and there is no reason why the brain should not suffer from the same cause, however the poison may be conveyed thither.'
- 60 For particularly clear examples of this tactic, see T.C. Graves, 'The Relation of Unresolved Infective Processes Following Acute Infective Diseases to the Causation of Mental Disorder,' *Journal of Mental Science*, 75, 1929, 31-44; idem, 'Non-Specific Therapy in Mental Disorder,' *The Lancet*, ii, 1932, 57-60, 115-21; idem, 'Head Injuries and Mental Disorder,' *Journal of Mental Science*, 84, 1938, 552-62.
- 61 *British Medical Journal*, ii, November 5, 1927, 817.
- 62 *British Medical Journal*, ii, November 5, 1927, 817. In fact, Cotton continued to employ abdominal surgery on an extensive scale right up to his death in 1933. See H.A. Cotton, 'Gastro-intestinal Stasis in the Psychoses,' *Proceedings of the Fifth International Congress of Physiotherapy* Liege, Belgium, 1930; Cotton to Adolf Meyer, April 29, May 8, 1933, Meyer Archive, Johns Hopkins University.
- 63 T. C. Graves & D.E. Turner, 'A Method of Continuous Colon Irrigation,' *Journal of Mental Science*, 76, 1930, 306-17 (an article which contains detailed blueprints for psychiatrists wishing to construct their own colonic machines). This less drastic alternative to colectomies was perhaps motivated by concern at the mortality associated with Cotton's more drastic abdominal interventions. Graves subsequently visited Cotton at Trenton to examine his procedures at first hand, and in 1929, he visited Norway, where Gjessing had become one of Cotton's most devoted disciples.
- 64 T.C. Graves, 'Non-Specific Therapy in Mental Disorder,' *The Lancet*, ii, 1932, 57-60, 115-21; 'Observations on Some of the Disturbances Referable to the Principal Sensory Fields in Cases of Oro-Naso-Pharyngeal Sepsis With Mental Disorder,' *Journal of Mental Science*, 77,

- 1931, 67-83; 'Sinusitis and Mental Disorder: Clinical Manifestations,' *Journal of Mental Science*, 78, 1932, 459-644.
- 65 Kathleen A. Sykes, 'The Routine Investigation and Treatment of Cases Admitted to Rubery Hill Hospital,' *Journal of Mental Science*, 79, 1933, 223-4. General paralytics were subjected to the same series of treatments, 'with the addition of a course of tryparsamide, frequent lumbar punctures, malaria, if they are considered well enough, or an extended course of colsal if not.'
- 66 T.C. Graves, 'The Common Cause in the Functional Insanities,' *British Medical Journal*, i, April 13, 1940, 608.
- 67 For example, in his official address to his professional colleagues, Daniel Rambaut, President of the RMPA from 1934-35 and Superintendent of St. Andrew's Hospital, Northampton, was critical of some of Graves' claims, but nonetheless conceded that the somatic treatments he had introduced had 'seen a complete change introduced into the spirit of the mental hospital.' He 'look[ed] upon it as our duty to make every attempt to improve the physical health of our patients, in the hope that by doing so we may remove some obstacle to mental recovery.' And he insisted that 'Even if one agrees with Dr. D.K. Henderson that several forms of physical treatment derive their benefit from faith and suggestion, they are worth pursuing empirically.' 'Some Recent Forms of Mental Treatment,' *Journal of Mental Science*, 80, 1934, 638.
- 68 The Superintendent at Powick, H.F. Fenton, was, in the words of Frederick Graves, 'a mouse of a man' completely intimidated by T.C. Graves, who 'kept him up to the mark.' Interview with Frederick Chivers Graves, July 31, 1986. Fenton used the profits from patients boarded at Powick by other local authorities to underwrite the construction of a treatment centre modelled on Rubery and Hollymoor. Cf. A.H. Ogden, op. cit., 1983, 5; and H.F. Fenton, 'Enhancement of Physical and Mental Capacity Following Treatment of Chronic Infective Disease,' *Journal of Mental Science*, 84, 1938, 544-51.
- 69 See 'Aural Sepsis in Relation to Mental Disorder,' *Journal of Mental Science*, 77, 1931, 193-5. Geoffrey Shera, 'A Special Method of Investigating the Streptococcal and Acidophilus Intestinal Flora: With Results in Fifty Three Mental Patients,' *Journal of Mental Science*, 76, 1930, 56-65; E. Goodall, 'ADD' *Journal of Mental Science*, 78, 1932, 746-50; W.A. Potts, 'The Diagnosis and Treatment of Some Physical Factors in Nervous Breakdown and Incipient Mental Disorder,' *Journal of Mental Science*, 81, 1935, 260-4.
- 70 See *Journal of Mental Science*, 79, 1933, 222.
- 71 F.A. Pickworth, quoted in 'Obituary,' *Lancet*, i, June 20, 1964, 1400.
- 72 See, for example, R.E. Jowett, 'Sinus Sepsis and Mental Disorder,' *Journal of Mental Science*, 82, 1936, 28-37; D. Rumbaut, 'Some Recent Forms of Mental Treatment,' *Journal of Mental Science*, 80, 1934, 630-8. The successive editions of D.K. Henderson's and R. D. Gillespie's *Textbook of Psychiatry*, (London: Oxford University Press) routinely surveyed these criticisms. See, for example, 1st ed., 1927, pp. 50-3; 5th ed., 1940, pp. 60-3; 6th ed., 1944, 61-5; 7th ed, 1950, pp. 66-71.
- 73 Interview with Dr. Valerie Graves, July 28, 1986.
- 74 The relative popularity of these new therapies is readily seen from the rapid rise in the space devoted to them in the *Journal of Mental Science* during these years. Where before, focal sepsis had been the source of a whole series of somatic treatments, now it had many rivals, at the same time as faith was waning in many quarters about its scientific merits.
- 75 Symptomatic of his growing isolation was his loss of control over one of the hospitals that formerly formed part of his empire. The appointment of J.J. Reilly as superintendent at the Winson Green Mental Hospital in 1939 was rapidly followed by the abandonment of the routine investigation and treatment of focal sepsis, and their replacement by ECT and occupational therapy, to both of which Graves was fiercely opposed. Cf. A.H. Ogden, op. cit., 1983, 6.
- 76 *Journal of Mental Science*, 86, 1940, 751-66.
- 77 For a similar verdict on this address, see A.H. Ogden, op. cit., 1983, pp. 5-6.
- 78 'Diphasic Vascular Variation,' 757, 760.
- 79 These included Bedford Russell of Barts, Patrick Watson Williams of Bristol, James Hogg and Samuel Birdsall of London, and R.S. Strang (Visiting ENT Surgeon to the Birmingham Mental Hospitals), together with F.A. Pickworth, the pathologist on Graves' staff.
- 80 'Symposium on Ear, Nose and Throat Disease in Mental Disorder,' *Journal of Mental Science*, 87, 1941, 477-528. (Quotations on 526-7.)
- 81 Ibid, 527.
- 82 Interview with Dr. Frederick Graves, July 31, 1986; T.C. Graves, 'Head Injuries: Their Psychiatric Sequelae,' *Journal of Mental Science*, 87, 1941, 552-62; idem, 'Contribution to

the Discussion of Major Palmer's Paper by the President, T.C. Graves, M.D.,' *Journal of Mental Science*, **81** Supplement, 1941, 10-14.

- 83 Interview with Dr. Valerie Graves, July 27, 1986. The production and use of crude penicillin filtrates was quite widely attempted in these years. For an overview, see Milton Wainwright, 'The History of the Therapeutic Use of Crude Penicillin,' *Medical History*, **31**, 1987, pp. 41-50 (which, however, contains no mention of Graves' experiments.)
- 84 T.C. Graves, 'Penicillin in the Psychoses,' *The Medical Press & Circular*, March 13, 1946, 172-8.
- 85 There is one very odd exception to this generalisation, which Dr. D.W. Millard has kindly drawn to my attention: from the late 1920s onwards, as we have seen, D.K. Henderson had been one of the most vocal and persistent critics of the focal infection doctrine, and he had made a point of roundly dismissing Graves' and Cotton's claims in successive editions of his textbook. In the eighth edition of 1956, however, a far more favourable assessment is offered (p. 66), for the first and last time. The authors point out that 'belief in the aetiological importance of focal infection has become greatly modified' but continue in a very different vein:

That, however, does not mean that we can afford to neglect its possible significance . . . we should never neglect in every case of nervous and mental illness to carry out physical examinations with the same meticulous care and standard as if the patient were in a general hospital. Failure to do so may lead to disaster both in relation to diagnosis and treatment. We are, therefore, indebted to Cotton in the U.S.A. and to Ford Robertson and Graves in this country who did so much to promote the view that the toxæmic aetiology of nervous disorder was of paramount importance.

Quite what explains this extraordinary *volte-face* is unclear. Perhaps the passage was written by Henderson's new co-author, Ivor Batchelor, and simply escaped his attention. The respectful tone remains, however, an isolated example of the doctrine being treated seriously at this late date, an ironic exception that proves the rule. Indeed, as Dr. Millard notes (personal communication), this passage 'was probably the final salute in the serious [psychiatric] literature to T.C.'

- 86 Interview with Dr. Valerie Graves, July 27, 1986.

26 Eliot Slater and the birth of Psychiatric Genetics in Great Britain

IRVING I. GOTTESMAN & PETER MCGUFFIN

Eliot Slater (1904-1983) was recognised in his lifetime as the doyen and founder of psychiatric genetics in Great Britain. The son of a schoolmaster, who was also a Shakespearean scholar, he was brought up in Oxford and educated at the Draper School and Leighton Park. After qualifying in medicine, he received a Rockefeller Foundation Fellowship to study and to become initiated in this field in 1934 in Munich and Berlin. He was recommended for this honour and award by his colleague Aubrey (later Sir Aubrey) Lewis (1900-1975), while the two of them were working under Mapother at the Maudsley Hospital, London.

Slater set off for Germany in a time of great turbulence, affecting the functioning of governments, economics, medicine, and science, which would be reflected for years to come in the structure of, and attitudes towards the discipline that began to grow at the interface of psychiatry and genetics. Industrialised societies were then afflicted with huge unemployment rates and consequent political unrest and reaction. In Great Britain, the general level of unemployment was 23%, while it reached 30% in Germany and the same levels in Scandinavia; labour unrest and strikes were endemic throughout Western Europe and extremist political movements sprang up on both the left and the right. In the German elections of 1932, the Nazi Party won 230 seats to 133 for the Socialists, 97 for the Centre, and 89 for the Communists. In the presidential race, Hitler lost to Hindenberg by 11 million votes to 18 million, but Hitler was appointed Chancellor in January, 1933 and immediately implemented dictatorial powers to further his megalomaniacal world view. In the next election, his Nazi Party received 92% of the votes. Dachau, the first of what would become over 1,000 concentration camps, was created by 20 March, to receive, first, political prisoners (mostly Communists) and later 'psychopaths', Gypsies, psychiatric patients, homosexuals, and Jews. (Some ten million prisoners were interned by the War's end in 1945, of whom half were killed). By July 1933, a compulsory sterilization law was promulgated with the purpose of 'preventing genetically diseased offspring'; a corollary was added five months later, authorising castration for recidivists, criminals and sex offenders.

Why, in spite of this troubled background, Germany should have been the place for a young psychiatrist to go and study genetics becomes clearer if we consider the history of the development of genetics in general and psychiatric genetics in particular.

The Beginnings of Genetics

British soil had been well prepared to nourish what would eventually become the field of psychiatric genetics. Charles Darwin (1809-1882) and his theories about evolution and natural selection (1859) captivated the minds of both scientists and the public, although such theories developed without a formal knowledge of the 1865 experiments of Gregor Mendel (1822-1884). These launched the science of heredity and genetics, which has become so essential to proving and understanding evolution, as well as the sources of the variation on which selection operated. Francis Galton (1822-1911), Darwin's cousin as well as friend and colleague (Desmond & Moore, 1991), was one of those inspired by the *Origin of Species* to think about the origins of individual differences in both morphological and behavioural traits in mankind. Independently wealthy, Galton rose to prominence as a Victorian scientist and science-populiser, despite only modest formal academic qualifications. He dropped-out from King's College Medical School, apparently for psychological reasons, and obtained a lowly pass degree in mathematics at Cambridge University (Slater, 1960/1971; Post, 1994). This self-made gentleman-scientist was, however, an undoubted genius, being the first to put forward the statistical concept of regression and correlation and the discoverer of finger-printing as an unique characteristic of individuals. He was elected FRS for his discoveries as an explorer in Southern Africa (1850-52), blessed by the Royal Geographical Society but carried out at his own expense. His ideas about the inheritance of behaviour were set out in detail (preliminary views having been voiced in 1865 in *Macmillan's Magazine*) in *Hereditary Genius: An inquiry into its laws and consequences* (1869), and were so clear that in Darwin's famous opus *The Descent of Man & Selection in Relation to Sex* (1871), evidence of an early convert to behavioural/psychiatric genetics can be found in the following: 'mental qualities, their transmission is manifest in our dogs and horses With man we see similar facts in almost every family; and we now know through the admirable labours of Mr. Galton that genius, which implies a wonderfully complex combination of high faculties, tends to be inherited; and, on the other hand, it is too certain that insanity and deteriorated mental powers likewise run in the same families' (1871, Vol.I, pp.106-7). Such a corpus of knowledge and ideas represents a clear foundation for the modern discipline of psychiatric and behavioural genetics, and it is difficult to forecast what would have evolved had the cousins not concerned themselves with this subject.

Galton, intrigued by the notion of being able to improve mankind in the same fashion as animal and plant breeders had changed these species, coined the term 'eugenics' in his 1883 *Inquiries into Human Faculty & its Development*. After some incubation, his utopian vision was put forward in 'public lectures in 1901 and 1904, with the hope that it might be implemented. He found ready audiences, not only in Great Britain, but also in Germany (Ploetz, father of *Rassen-biologie*) and the United States (Davenport 1866-1944). These included not only scientists (Karl Pearson [1857-1936], his first disciple, and the young Cyril Burt), but also politicians, patricians, and the intelligentsia of the day (e.g., Mott, Tredgold, H. J. Laski, H.G. Wells, and G. B. Shaw). Within a short time, Pearson, Weldon, and Galton founded *Biometrika* (1902), and the newly formed Eugenics (Education) Society began to publish the important journal *Eugenics Review* (now known as the *Journal of*

Biosocial Science). Galton founded and funded a National Eugenics Laboratory at University College in 1904. Most likely, these elements in the foundation of psychiatric genetics were put into place with no knowledge of the formal laws of inheritance discovered by Gregor Mendel, a biologist and reluctant abbot, who had experimented in near obscurity in his monastery garden in Brno, Moravia.

It was not until 1900 that three botanists independently – Correns in Germany, de Vries in Holland, and Tschermak in Austria – rediscovered Mendel's research papers, and the knowledge spread rapidly around the world. In Britain, the biologist William Bateson (1861-1926) took up the cause, and named the new and expanding field 'genetics' in 1905, as well as inventing the terms 'homozygote' and 'heterozygote'. Subsequently, the Danish biologist Wilhelm Johannsen developed the term 'gene' in 1908, for what Mendel had been calling 'elements' as well as the terms and essential distinction between 'phenotype' the observed appearance, and 'genotype', the (then unobservable) underlying genetic endowment. Instead of synergising that which Galton and Pearson had unknowingly developed as the 'quantitative genetic' or biometric approach to the problems of human heredity, the qualitative approach of 'mendelism' was perceived as antagonistic and wrong-headed by many eugenics enthusiasts. Many years would be wasted in internecine warfare before the two factions could be brought to the epiphany of understanding that both approaches are essential and were really manifestations of one unified genetic model. This story has been told in detail by Kevles (1980, 1985) and Provine (1971), but critical steps in it were the research of W. Weinberg, 1908-1910 [cited in Stern, 1962], R.A. Fisher (1918, 1930), Sewall Wright, and J.B.S. Haldane. Bateson's appreciation of Mendelism led, via consultation, to Archibald Garrod's early identification of one inborn error of metabolism, alkaptonuria, as a mendelising recessive disorder. Thus was launched modern biochemical/medical genetics; Garrod's Croonian lectures were published in 1909 (cf. Harris, 1963) as *Inborn Errors of Metabolism*.

Genetics and Psychiatry in Germany

Little substantive research in what was relevant to psychiatric genetics, however, took place in Britain until the 1930s. By contrast, significant developments occurred in Germany, where Correns had recovered the genetic theories of Mendel and where for decades, the vast majority of doctors, public health authorities, biologists, and anthropologists, had been extremely enthusiastic about the ideas of Darwin and Galton. Ploetz (1860-1940) became the first editor of *Archiv für Rassen-und Gesellschaftsbiologie* in 1905, and in the following year, founded the Society for Racial Hygiene with Ernst Rudin (1874-1952), who was also his brother-in-law. Both shared various utopian ideals and were zealous temperance advocates. In 1903, Rudin advocated eugenic abortion for alcoholics, as well as sterilisation for those of them who wished to marry, as alcoholism was clearly, to him, hereditary (Proctor, 1988; Weindling, 1989, p.186). In a chilling portent of the murder of mental patients under the Nazis, Binding, a jurist, and Hoche, a psychiatrist, wrote persuasively in 1922 *The Sanctioning of the Destruction of Lives Unworthy to be Lived*, a rationalisation for an apocalyptic euthanasia. [We are grateful to Professor Peter Propping, Head

of the Institute of Human Genetics at Bonn University for calling our attention to this rare source.]

A key event in this history was the appointment of Emil Kraepelin (1856-1926) as Professor and Director of the new Psychiatric University Clinic in Munich in 1904, when he moved from his Professorship in Heidelberg, soon followed by Rudin. Kraepelin's genius for nosology and the organisation of research provided an ideal setting for rapid advances in psychiatry, and particularly in psychiatric genetics. By 1917, the very first 'research institute' for psychiatry - the Deutsche Forschungsanstalt für Psychiatrie - was in place, with Rudin as head of the Department for Genealogical Demography. Kraepelin had earlier encouraged Rudin to study dementia praecox from a Mendelian viewpoint, resulting in the first major family study that was scientifically sound, including a study of adoptees (Rudin, 1916). Preliminary findings were available in 1911, and were mentioned by Eugen Bleuler (1857-1939) in his classic monograph on dementia praecox, in which he put forward the alternative and now universally adopted term 'schizophrenia'. Rudin's data have stood the test of time, and his two-locus recessive model was remarkably ahead of his era. Most authorities now accept that the inherited component in schizophrenia in most cases is probably oligogenic, determined by two or more genes, or polygenic, determined by multiple genes, each of small effect.

Before long, a full repertoire of genetic strategies to study neurological and psychiatric disorders were available in the Institute, which eventually became a model adopted around the world, including the Maudsley Hospital and the National Institute of Mental Health (USA). This scheme combined a comprehensive mental hospital, with units for numerous basic and clinical sciences, facilitating collaboration among clinicians and researchers. German science was then admired worldwide, and its scientists were capturing more than their fair share of Nobel Prizes in numerous fields. In 1924, Rudin's recruited two collaborators, Hans Luxenburger (1894-1976) and Bruno Schulz (1890-1958), who initiated systematic research into the genetic aspects of mental disorders, setting the standard for others to follow (see Essen-Møller, 1958 for Schulz's obituary and Schulz, 1953 for an insightful memorial to Rudin). The use of twins to unravel 'nature versus nurture', sketched in a far-sighted if crude fashion by Galton in 1875, was formalised in a scientifically useful form by Siemens (1924) in Germany, and first used to great advantage in Rudin's group. Demography was developed as a necessary companion to the family studies, so as to establish the critical benchmark of a general population base-rate or 'lifetime morbid risk' for each disorder; Rudin had begun a *total registration* of the Bavarian population in 1921. What better setting could a novice want for a postdoctoral experience?

Early Interest at the Maudsley

Aubrey Lewis, who was erudite and multilingual, and in Shepherd's (1986) view, 'the most eminent psychiatrist of his day', was fully informed about the advanced state of knowledge in Munich. One of his first papers (1931) dealt broadly with genetic problems in psychiatry 'and their solution by the study of twins'. Shortly after he had emigrated to the Maudsley Hospital from Austria in 1929, he

foresaw the need for a register of twins from consecutive admissions to a mental hospital, so as to provide an unbiased sample – a suggestion he was to implement at the joint Bethlem Royal and Maudsley Hospitals for Slater in 1948. He had already travelled extensively as a Rockefeller Foundation Fellow, initially to prepare for a career in psychological anthropology and psychological medicine, visiting Adolf Meyer (1866-1950) in Baltimore, as well as Heidelberg and Berlin. Slater arrived to join the staff at the Maudsley in October, 1931, having been invited by Mapother. Lewis was immersed in genetic writings, one of his many interests; he was preparing to review the state of knowledge about the inheritance of mental disorders for the Eugenics Society (1933) and doing the library research for a definitive chapter on this topic for the prescient book entitled by C.P. Blacker *The Chances of Morbid Inheritance* (1934). The latter chapter was masterful, scholarly, and critical; from the dates in the bibliography, it appears to have been completed early in 1932. This date is important, as neither Hitler not the first of the Draconian eugenics laws were yet in place. Lewis, of Jewish origin and liberal political persuasion (if authoritarian in personal style), could understandably say (1934, p.87), ‘during the last twenty years painstaking work has wiped away the reproach from genetic psychiatry, that it was bad psychiatry and bad genetics. This has been due to a few men, the foremost among whom is Rudin; his studies [1916] have been the starting point and model for almost all of value that has been done so far in this field’.

Slater, casting about for some specialty as a researcher, eagerly received the copy of the doctoral dissertation on the clinical features of melancholia proffered by Lewis [1930, Adelaide] and devoured it (Shields & Gottesman, 1971). Slater was very impressed with Lewis’ critical thinking, and found him to be stimulating but exasperating; he enjoyed attending the fortnightly ‘literature club’ arranged by Lewis, and quickly took up his suggestion to work on a paper in the genetic epidemiology of mental disorders in Great Britain to fill a void in knowledge and to parallel the work completed in Germany. This led to Slater’s first published paper (1935), now a classic in the field, and on which he took advice from R.A. Fisher; who accepted it for it *The Annals of Eugenics* (now *The Annals of Human Genetics*), a journal then edited by him. Again on the advice of Lewis, and endorsed by Mapother, Slater sought and obtained a Rockefeller Foundation Fellowship to pursue genetics in Rudin’s department. Lewis had suggested that expertise in either neuropathology or genetics would lead to a promising future for a research psychiatrist, and Slater quickly selected genetics. In the Autumn of 1934, Eliot Slater began a new life in Munich, replacing the previous Fellow, Erik Essen-Moller of Sweden.

Slater’s Pre-War Contribution

Slater arrived in Hitler’s Nazi Germany with very mixed emotions. Because Mapother had prevailed upon the Rockefeller Foundation to provide financial support to German Jewish refugee psychiatrists, Slater, before he left London, was able to meet Eric Guttman, Alfred Meyer, and Willi Mayer-Gross, who had been placed at the Maudsley. They became instant colleagues and, in time, co-authors. The Nazi law of April 7, 1933 for the ‘restoration of the professional civil service’ forced the dismissal of all Jews and half-Jews from any

government position, including universities, research institutes, and hospitals. The psychiatrist and geneticist, Franz Kallmann, for example, a 'half-Jew' emigrated to New York in 1936. Adding further injury, the Nazi law on compulsory sterilisation for the prevention of hereditary diseases was announced July 14, 1933, to become effective in 1934 (cf. Muller-Hill, 1988; Proctor, 1988; Weindling, 1989). The 'diseases' concerned are depressive insanity, inherited epilepsy, Huntington's chorea, inherited blindness, inherited deafness, severe inherited physical malformation, and, anyone 'suffering from severe alcoholism'.

Word of this proposal spread like wildfire and the August 5, 1933 issue of *The Lancet* contained an unsigned Leader with a very sharply worded alarm, even before the text of the German law was published in the journal on September 2. It warned of a spirit between 'irresponsible extremist' implementation of the ideas of eugenics in Nazi Germany and the humane interpretation prevailing in England (cf. Penrose, 1967), with an immediate danger of the abuse of human rights of Jews and mental patients. The writer excoriated the law for 'gross overstatement of our present knowledge of heredity, a disregard for the individual human being, and a willingness to act upon racial prejudice . . . intelligence and humanity are less respected than ruthless devotion to the State [and] misstatements and exaggerations [leading to] a system of compulsory interference with the liberty to propagate, the total effects of which, though difficult to foresee in detail, can scarcely be other than bad (p.298).' Many years later, it emerged that the author was Aubrey Lewis (Shepherd, 1986), writing from the joint vantage point of being a Jew and a genetically-informed psychiatrist. His early warning was confirmed in a more extensive treatment of German eugenic legislation (Lewis, 1934). There, it was made clear that Rudin was one of the main authors of the law, and that it was projected that 400,000 citizens, including children over the age of 10, would be suitable for sterilisation; 360,000 of these were psychiatric patients. Although compulsory, the decision on sterilisation in any case was to be taken by the 'nicety' of a nation-wide set of 205 Eugenic Courts (plus 31 oversight courts), consisting of a lawyer, a public health doctor, and one 'versed in eugenics' (Lewis, 1934; Lifton, 1986; Proctor, 1988). Not knowing what the immediate future would hold, Slater was put into the good hands of Bruno Schulz, of whom he would later (1971, p.18) say '[his] political integrity was the equal of his scientific honesty', i.e. he rejected Nazi ideology and did not compromise his findings for their purposes.

With the 'kind permission of Professor Rudin', whom he only met twice and that socially – in the course of a year, Slater commenced the study of three generations of manic-depressive families. These consisted of 315 probands with recurrent affective disorders and their parents and children.

It was to be his first major contribution. Although he later wrote self-deprecatingly of his linguistic ability on first arrival, his fluency in German eventually became good enough for him to conduct extensive interviews in the field with most of the 209 offspring. The probands had been selected from the 3,000 cases admitted to Kraepelin's clinic with a hospital case-note diagnosis of manic-depressive insanity (1904-1922) which had been collected in Rudin's department. In a stroke of genius, Slater kept himself blind to the diagnosis of family members, and later enlisted Mayer-Gross and Guttman at the Maudsley as blindfolded judges of the case histories. Such a research strategy would reappear many times in the future as one of the hallmarks of Slater's

influence (e.g., Gottesman & Shields, 1972; Farmer et al, 1987). As a further innovation, he applied three different methods of age-correcting the same data sets, including the one he and Erik Stromgren had devised independently in 1935 that used weights based on the age-structure of both the general population and the age of onset for manic-depression in a representative patient population. (These were not the probands under investigation for a family study.) In one more methodological innovation, he was the first to use analysis of variance in psychiatric research, when he tested for idiodynamic variation in the periodicity of affective episodes and found it to be present. He again took the advice of R.A. Fisher on this problem (cf. Shields & Gottesman, 1971 for English translations by James Shields of the seminal German papers).

It is of historic interest to record the age-corrected risks for manic-depressive disorders plus 'spectrum' disorders (= 'cycloid psychopaths') that Slater observed among the parents and the offspring of his probands, as these have stood the test of time. The risks in parents were 19.2%, and in children, 29.2%. Invoking a 'meta-analysis' of the 17 general population studies available in the literature, he concluded that the risk of manic-depressive psychosis in parents, sibs, and children of manic-depressives, phenotype-defined so as to have a lifetime risk of 0.3805%, was increased by 30-60 times. He also reported, confirming Luxenburger, that the disorder was not accompanied by downward social mobility for the families. As part of his Fellowship, Slater spent three months in Berlin, learning both basic and Drosophila genetics in the laboratories of Timofeeff-Ressovsky; he reused some of the concepts, required e.g., penetrance and genetic background, in his research on mental disorders, which represented another innovation transmitted to his intellectual heirs. His cathexis to mathematics and quantification has served the field of psychiatric genetics well as a superego. The value of testing the fit of the data to different models of genetic transmission was also initiated in Slater's manic-depression research; ahead of his time, he rejected the suggestion of hypotheses invoking a sex-linked gene to account for the apparent female excess for the disorder (cf. McGuffin *et al*, 1994).

At the research institute, Slater met Lydia Pasternak, a chemist and daughter of the artist Leonid and sister of the poet/novelist (later Nobel laureate) Boris, and they became engaged. Upon returning to England at the end of 1935, they married, which would have been illegal in Germany, as she was Jewish according to the Nuremberg Laws of 1935 (Proctor, 1988). As a consequence of the Rockefeller fellowship, Slater began lifelong associations with Erik Essen-Moller and Franz Kallmann, both of whom would also carry out their own twin studies of mental disorders; Kallmann was forced to emigrate from Berlin, with a total of 20 marks as his financial assets. In one of Slater's first papers, published on his return to England in the *Eugenics Review* (1936), he said, echoing Lewis' earlier outrage, 'The fuehrer directs with a series of ukases. With successive hammer blows, the German citizen is driven into a swastika-shaped hole. The atmosphere of compulsion pervades the whole of his life. The fact that he and fellow men are now to be selected and bred like a herd of cattle seems to him hardly more distasteful than a hundred other interferences in his daily life. . . . The command now is to breed' (Slater (1936) reprinted in Gottesman & Shields, p.292).

Upon his return to the Maudsley, Slater obtained a grant from the MRC

that permitted him to spend the next two years collecting data from the ten London County Council mental hospitals on all those among the standing population of 20,640 patients who were one of twins, without regard to specific diagnosis. Thus, all audit patients were included, irrespective of their disorder. An additional 364 patients were identified through circulars sent to relatives of the patients. However, research and all other life was disrupted by the outbreak of World War II in 1939. The hospital was evacuated, with Lewis in charge of one-half at Mill Hill, while Slater, still just 35 years-old, was in command of the other unit at Sutton.

The War Years

Some 20,000 military psychiatric casualties passed through Sutton while Slater and his staff were providing the medical care; research was not ignored, and the men were asked about their twinship and family histories. Of most importance to this history is the work leading to a general theory on the aetiology of neuroses, a wide-ranging diathesis-stressor theory, specifically polygenic on the diathesis side and multifactorial; military stress was even quantified into severe, moderate, and trifling. Slater's bibliography (Shields & Gottesman, 1971; Roth & Cowie, 1979) reveals an extensive list of his accomplishments and co-workers. Two thousand soldiers (a few were airmen and sailors) made up the sample for much of the neurosis work, while a subsample of 100 and their spouses was the subject of a book with Woodside (1951) on marriage and assortative mating. Using a checklist that anticipated structured interviews and modern computerised schedules, social, demographic, and psychological data were collected and subjected to entry on Hollerith Punch Cards, so that the counting and cross-tabulating could all be automated for the answers, mostly given as 'yes or no'. The stressors experienced by neuropsychiatric admissions from November, 1939 to June, 1941 were considerable. Papers on the 'neurotic constitution' and a heuristic theory of neurosis were published with his brother Patrick, a psychologist and statistician, in 1943 and 1944, while Slater himself maintained full clinical duties. Contemporary concern with post-traumatic stress disorder (PTSD) would benefit greatly by a review of this work, including joint papers with his colleague and friend Will Sargant and with Aubrey Lewis. The diathesis-stressor model developed then was the first to emphasise a polygenic component on the diathesis side of the model; they concluded that the neurotic constitution (further refined ICD-like components) was a 'useful hypothesis', and that neurochemical investigations in the future were warranted. Also innovatively, the Slaters used a form of factor analysis, principle components analysis, and intraclass correlation coefficients in their work. Their heuristic summary (1944/1971, p.227) was that:

In so far as the effects of the genes are qualitatively dissimilar, the types of stress effective in producing breakdown, and the neurotic symptoms, will tend to differ. The neurotically predisposed man is then to be regarded as a man who has a more than average susceptibility to environmental stresses of one or a number of kinds; he represents one of the extremes of normal human variation.

Postwar and the (First) Golden Era of Psychiatric Genetics

The to-be-classic twin study of psychotic and neurotic illnesses in twins was re-started in November, 1947, when Slater had the good fortune to take on James Shields (1918-1978) as his Research Associate. Shields, an unassuming and self-effacing but brilliant man, had been formally trained as a psychiatric social worker, and learned perseverance and perfect German while a prisoner-of-war for five years after Dunkirk. Among many honours earned for research in behavioural and psychiatric genetics (Gottesman, 1979), was an Honorary Degree of Doctor of Medicine in 1975 from the University of Zurich, which was recommended by Manfred Bleuler and Jules Angst. Shields followed-up the pre-war sample and extended the study to new cases; he and Slater prepared the material for publication (1953) in such a fashion that future workers could re-analyse the raw data; of the 385 pages, 271 contained case histories and 24, appendices. Speculations about modes of inheritance for any of the disorders studied are conspicuous by their absence; best lifetime estimates of diagnoses for this unselected sample were made, warts and all (Shields, 1979). The conclusions were typically modest, but it was clear that the psychiatric genetics of psychoses, neuroses, and personality disorders would advance.

Subsequently, in a masterful but short paper (1958), Slater put forward a monogenic theory of schizophrenia that reads as if it could have been written two or three decades later. The Medical Research Council recognised that the time had come, and appointed Slater as Director of its new Psychiatric Genetics Unit at the Institute of Psychiatry, where he was Senior Lecturer, in 1959. The Unit was to grow to and radiate its influence worldwide for the next ten years. The staff consisted of Slater, Shields, and Valarie Cowie, who had become affiliated in 1957, as well as remarkably talented 'secretaries' who did double duty in a variety of essential roles as research assistants. Cowie, trained as both a psychiatrist and a human geneticist under Lionel Penrose at the Galton Institute, added expertise in the still comparatively new fields of cytogenetics and biochemical genetics (Cowie, 1970), and brought with her a neurodevelopmental perspective. Slater encouraged Shields to develop his interests in the genetics of normal personality trait variation, resulting in the classic study of 44 monozygotic twins reared apart (MZA), as well as 44 monozygotic and 32 dizygotic pairs reared together (Shields, 1962). Most of the twins were identified through their having seen a TV programme, *Twin Sister, Twin Brother* on the BBC in November 1953; it is amazing that 5,000 twins replied to a questionnaire printed in the *Radio Times*.

At the same time, Slater took up the duties as Editor-in Chief of the *British Journal of Psychiatry* (1961-1972), known as the *Journal of Mental Science* before 1963. The importance of that fact to the history of psychiatric genetics cannot be overlooked. Through his reputation and mentorship of younger scientists, many papers were attracted and published that could not find a home elsewhere, given the hostile and uninformed views toward the field at the time. A slow but steady stream of postdoctoral fellows from around the world came to the new and enlightened mecca of psychiatric genetics; the field was dead in Germany for the reasons cited above. It is a historical curiosity, though, that Slater contributed a paper to the *Festschrift* for Rudin's seventieth birthday (1939), and that Kallmann appeared as a character witness at the latter's Denazification Tribunal in Nuremberg, at which he was found

guilty at the lowest of culpability, 'fellow-traveller' and sentenced to one year's confinement.

Slater's influence, as well as that of Shields and Cowie, can often be recognised in the papers produced by the foreign visitors: Fonseca (Portugal), N. Parker (Australia), K. Abe (Japan), M.T. Tsuang (Formosa/USA), Gottesman (USA), Kringlen (Norway), Heston (USA), de Francisco (Mexico), and Carey (USA). Shields (1968) has provided a detailed overview of the breadth of activities conducted at the MRC unit during its ten-year existence that coincided with Slater's 'retirement' at the age of 65 in 1969. He then kept up with many of his scientific interests and managed to earn a PhD in English Literature at Cambridge in his 76th year; his thesis was published (1988) after his death.

Given Slater's scientific philosophy, which valued any empirically demonstrable cause or contributor to the aetiology or manifestation of mental disorders, he was quite concerned about the issues surrounding aetiological heterogeneity. Non-genetic, schizophrenia-like, and schizophreniform psychoses attracted his attention, in the hope that their definition and identification would leave the field clearer for the identification of the genetic contributors to schizophrenia. The programme of research with Beard and Glithero (Slater *et al.*, 1963) on the phenomenology and familiarity of the schizophrenia-like psychoses of epilepsy is the fruit of such an open-ended approach to knowledge. In many ways, his entire research career involving psychiatric genetics and its underpinnings in psychology and mathematics culminated in the first English-language textbook focussed on the genetics of mental disorders. Slater & Cowie's (1971) *The Genetics of Mental Disorders* stands as a monument to mark the jumping-off point for the modern era of psychiatric genetics.

Envoi

In the course of writing his autobiography and a 'retrospect' (Shields & Gottesman, 1971), somewhat reluctantly at first and then with enthusiasm and too much candor for his own self-interest, Slater provided some guidelines for those who would follow in his footsteps for psychiatric genetics. They could also serve as his epitaph.

It is a pity to be blinded by emotion; but it is the wilful self-binding which causes so much of the avoidable difficulties against which workers in such fields as psychiatry and behavioural genetics have to pit themselves. It is indeed necessary to take up a position, for argument's sake, or to have a point of departure for further work. But such positions are necessities of convenience and should claim no loyalty. We must not weep when we are forcibly moved on, or compelled to retreat. (p.377)

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27 Fairbairn

DIGBY TANTAM

William Ronald Dodds ('Ronald') Fairbairn was born in 1889 and brought up in a genteel suburb of Edinburgh, the only child of a distant father and an omnipresent and ever-watchful mother (these details are taken from the biography of Fairbairn by Sutherland, himself an influential Scottish analyst and ex-colleague and ex-analysand of Fairbairn's: Sutherland, 1989). He read philosophy as an undergraduate at Edinburgh University (his father prevented him from going to Oxford), but spent short periods at the Universities of Kiel, Manchester, and Strasbourg. After graduation, he studied divinity in London and then began to train for the Presbyterian ministry, back in Edinburgh. After the outbreak of war, he joined the University Officer Training Corps and was called up for Army service in 1916, after an operation to remove a varicocele which had originally made him unfit for service. He served in Scotland as an artillery officer until 1917, when he went to Palestine with his battery. He had a period in an Army hospital that year, and was demobilized at the end of 1918. After leaving the Army, he decided not to continue his theological training but, presumably as a result of his observations of military psychiatry, to train as a psychotherapist via qualification in medicine. He was analysed by Dr. E. H. Connell, an Edinburgh medical psycho-analyst, and subsequently by Ernest Jones. Fairbairn began his private analytic practice in 1925, when he was aged 36, and continued in it until his retirement, though with a reduction during the second world war when he also assessed patients at the military hospital in Carstairs.

He married at the age of 37, and there were 3 children over the next 7 years. By the time of the birth of the younger son, the Fairbairn's marriage had deteriorated and it never fully recovered, according to the reports given to his biographer, Sutherland. His wife is reported to have felt neglected by Fairbairn's punishing schedule of analysis during the day and writing at night. She died in 1952 and Fairbairn married a second time, to his secretary, in 1958.

In this chapter, I discuss the ideas that make Fairbairn's contribution of continuing interest to psycho-analysts. I argue that his theories about ego formation can be readily translated into contemporary emotion theory, and that to do so is worthwhile because there is still much to learn from them. The recent publication of previously unpublished papers (Scharff & Fairbairn, 1994), unfortunately too late for inclusion in this chapter, demonstrates a rekindling of interest in his work which reflects this contemporary relevance.

Background

Fairbairn's written style is to strive for precision of language and thought. It is highly theoretical, and much less engaging than that of other object-relations theorists with whom he is grouped. The object-relations approach to psychoanalysis was initiated by Klein and extended by other psychoanalysts who were influenced by her, including Winnicott, Balint, and Fairbairn himself. Fairbairn's contribution to object-relations theory was recognized by Klein, who incorporated his ideas about the relations between the infant and the social world into her conception of the paranoid position, which she re-named the 'paranoid-schizoid' position in acknowledgement of Fairbairn's formulation of the 'schizoid' position of the infant. However, Fairbairn never became a leader of the object-relations group, was never recognized as a major theorist, and introduced no new clinical methods. His ideas have never escaped the technical psycho-analytic literature, failing to break out into either psychiatry or public awareness.

He was less able to attend psycho-analytic meetings than London-based colleagues or to analyse trainees, few of whom were able to travel to Edinburgh. In his forties, after the death of his father who had suffered from a fear of urinating in public, Fairbairn also developed this problem (Sutherland, 1989). This interfered with his ability to travel to meetings or to give lectures.

His often-cited geographical isolation in Edinburgh, though, cannot be the explanation. Fairbairn's contemporary in Edinburgh, Henderson, is, after all, immortalized in the name of a famous hospital in the south of England. Why, then, does Fairbairn merit a whole chapter to himself?

I think that two answers could be given, equally validly. The first is the one that has been proposed by other Fairbairn apologists: that by discarding traditional drive theory, and replacing it with innate pro-social competencies, Fairbairn freed metapsychology from its inappropriate biological trappings. This step, large enough for Sutherland to term it Copernican (Sutherland 1989), is equivalent to that taken by Piaget in describing the unfolding cognitive development of the infant. The second answer to why there should be a chapter on Fairbairn is that he offered an answer to the existential predicament that is, arguably, central to late twentieth century life: of, to use Sutherland's words, 'being made . . . afraid to love by the fear of rejection'.

Fairbairn tried to develop a complete intellectual system, and more and more depended on his own terminology and psychological perspective, rather than linking his ideas into an existing body of knowledge. He acknowledged his debt to Klein, but not to other contemporaries such as Suttie, whose ideas were similar to his on a number of matters. Other people accused him of over-estimating the importance of his ideas. He was accused, for example, of wishing that his 'theory supplants that of Freud. If Fairbairn is right, then we teach Fairbairn and not Freud to our students' (Winnicott & Khan, 1953).

Had Fairbairn had a stronger group of supporters, as Melanie Klein did, none of this might have mattered. He did have Harry Guntrip, a Congregational minister who had become a psychotherapist and then, at the age of 48, had further therapy with Fairbairn. Guntrip chose Fairbairn because he expected to agree with his views and, perhaps because both had a religious background. Guntrip was in therapy with Fairbairn for 11 years, and subsequently with Winnicott (with

whom he compared Fairbairn's analytic method unfavourably (Guntrip, 1975). Guntrip became a stout exponent of Fairbairn's views, despite his therapeutic disappointment. *Personality structure and Human Interaction* (Guntrip, 1977) is the most systematic account of Fairbairn's work. It was Guntrip's purpose to turn psycho-analysis from a 'neurophysiological and psychobiological philosophy of man, using the instinct concept as the basis of theory, into a truly psychodynamic theory of the personality implying a philosophy of man that takes account of his reality as an individual person' (*ibid.*, p.17).

Fairbairn may well have shared these views: Robbins (1992) considers that he anticipated self psychology and that when Fairbairn wrote about 'ego', he was writing about what other therapists would later call the self, and what Guntrip termed the 'person'. Fairbairn's emotional preoccupations were also more personal than his predecessors. If Freud was coming to terms with lust, and Klein with rage, Fairbairn was searching for love.

Fairbairn's clinical method

Towards the end of his career, Fairbairn was critical of the one-sidedness of the analytic method: 'since inhibitions upon activity constitute such an important factor in the genesis of symptoms and inner difficulties, it becomes a question whether the artificial reinforcement of such inhibitions by the conditions of the analytic session does not in many cases constitute a serious emotional trauma for the patient, increase his resistance and perhaps even favour negative therapeutic reactions' (Fairbairn, 1957). He also came to believe that 'The relationship existing between patient and analyst is more important than details of technique' (*ibid.*, p.59). But Fairbairn remained cautious about introducing new therapeutic developments: 'the practical implications of my views have seemed so far-reaching that they could only be put to the test gradually and with the greatest circumspection' (Fairbairn, 1958).

Fairbairn's published case histories show him to be able to capture the existential situation of the person caught in the grip of separation-anxiety, or unable to love because of the fear of rejection. To my mind, his descriptions of other conditions disclose much less sympathy with the patient's dilemma and, perhaps, less clinical perspicacity. His report of a patient with pseudo-hermaphroditism, possibly due to congenital adrenal hyperplasia (Fairbairn, 1927), includes no empathetic account of the existential dilemma of not knowing what one's true sex is, of never being able to have intercourse, and of not being able to conceive.

Fairbairn's apparent detachment is shown even more clearly in his account of another female patient (Fairbairn, 1931). She had never seen her father, who had never lived with her mother; the father had a drinking problem, and there was a family history of depression. Fairbairn suggests that there had been a sexual relationship with her brother. She had no other sexual relationship, had few social contacts, attributing her social isolation to the tyranny of an older sister, and had been unable to work for ten years because of her psychological disorder, the symptoms of which included a preoccupation with self-harm, visions, inability to cope with the demands of life, disturbed sleep, and phantom pregnancies. No concept of the borderline patient existed at the time that Fairbairn described

this case, but it is surprising that he thought it wise to offer her a short course of analytical treatment designed to mitigate her symptoms. In fact he treated her, on and off, for seven years, during the last 15 months of which, when he was seeing her 'from time to time', she began to lose weight and eventually died of inanition. Fairbairn writes, 'my last visit was on the day before she finally faded away and died . . . I was not able to learn a great deal about the experiences through which she was passing . . . but, unless my memory deceives me, she was definitely entertaining sexual phantasies. Be that as it may, it is quite certain that she was in a state of extreme sexual desire; and, when I left her moribund on the occasion of my final visit, almost her last words were, "I want a man" . . . Can she be said to have died of unsatisfied sexual desire? Or did she die of masturbation? Or did she kill herself by means of repression?' (Fairbairn, 1931).

Perhaps it is understandable that Fairbairn did not recognise anorexia nervosa since, although cases had been published, the diagnosis was not widely known at the time (it was 1951 when he wrote the supplementary note about this case in which he describes her death). What is strange and disturbing is that Fairbairn seems to have exerted himself so little to save her life, but yet was able to continue observing her. Applying Fairbairn's own yardstick for intimate relationships, was his action loving, or withholding? I think that the latter probably is closer to the mark.

Fundamental questions

Certain questions dominate psychoanalytic psychology, and each theorist has to consider them. Some of them – less than Freud might have thought, perhaps – are questions about sexuality. Even though the range and variation of sexuality is far less of a surprise in this century than it appears to have been in the last, and there is less cause for concealment, the cogency of sexual desire and its ability to lyse other social ties evades satisfactory explanation. Even more pressing are questions about aggression. Why do people hurt each other? What can lead a person to kill sadistically, to batter a baby, or even to humiliate someone to the point of tears? Even – and this is a question that Freud linked to the existence of aggression – what satisfaction is there in the repetition compulsion, a kind of involuntary self-harm in which a person repeats ways of dealing with people and problems that lead inexorably to disappointment.

Fairbairn thought that analysts exaggerated the importance of sexual pathology which, in his view, was simply one special type of object-relating. He writes for example: 'there has been a widespread movement among psychiatrists towards the point that perverse sexual tendencies are "symptoms" . . . but this is a point of view which I cannot see my way to share' (Fairbairn, 1946b). Fairbairn, like Klein, was preoccupied by aggression, particularly as in its expression as a stubborn reluctance on the part of his patients to give up their symptoms. However, he attributed it not to an inborn 'death instinct', which he rejected, but to the consequences of a failure of care. Guntrip considers that Fairbairn is preoccupied with dependency, but this is too narrow. The questions which dominate his writing anticipate Bowlby and the attachment theorists: why are some people incapable of love, or of being loved? Why do people hate?

The answers to these questions were conceived within an intellectual tradition

that had already become alienated from psychology and has become even more so with the passage of time. This can most readily be illustrated by his last published paper (Fairbairn, 1963), a synopsis of his object-relations theory of the personality. In this two-page paper, he reduces his theory to 17 points, of which the following present particular problems of definition:

- (1) An ego is present from birth
- (2) Libido is a function of the ego . . .
- (5) The ego, and therefore the libido, is fundamentally object-seeking.
- (7) Internalisation of the object is a defensive measure originally adopted by the child to deal with his original object (the mother and her breast) is so far as it is unsatisfying.
- (9) Two aspects of the internalised object, viz – its exciting and its frustrating aspects, are split off from the main core of the object and repressed by the ego

What should a developmental psychologist understand by 'ego'? What is libido? What is an object? Clearly, internalised does not mean taken into the body, but if it means 'taken in' as in 'This is a difficult idea, but I do feel that I have taken it in', then how could that be a defensive procedure and how could it apply to anything other than ideas? Fairbairn writes that internalisation is a 'distinct psychological process', but what does that mean? Further difficulties are created by other favoured Fairbairn words like 'structure', and 'identification'.

These neologisms or words used in unusual contexts are obvious candidates for puzzlement, the words 'birth' and 'child' also have as uncertain a meaning in Fairbairn's writing as they do in the writing of other less precise theorists (Stern, 1985). Does he purport to be describing an actual developmental process? Neonates seem to be attributed with a good deal more purposiveness than would normally be associated with this pre-verbal period. They behave a good deal more like an adult would imagine that an infant might behave. It seems that the Fairbairnian infant – indeed the psychoanalytic infant – only exists as a character in the narrative between analyst and patient. This narrative has a special character. It is preoccupied with the past, is limited to family doings, and is intensely moral. Someone is definitely to blame for things. Fairbairn's account of who it is marks an important break from Melanie Klein. She argued that it is the infant him- or herself whose aggression (the death instinct) is so intense that it imperils his or her receipt of care. Fairbairn, like Sullivan, blamed the failure of care-giving onto the empathetic failure of the care-giver, and subsequent psychoanalysts have tended to side with Fairbairn.

It is my intention to describe Fairbairn's work within a wider psychological discourse than is customary in object relations theory. To do that, I need to get out of the way some of the words that Fairbairn uses. Doing so will also be an opportunity to describe some of the details of his metapsychology.

Libido and ego

One has to understand that psychoanalytic 'metapsychology' 'presents the person as a mental apparatus within which forces – so-called 'psychodynamics' – and the functions of mental structures are at work, each in their own way' (Schafer,

1987). Psychoanalysis, because of these origins in the epistemology of the physical sciences, is therefore committed to providing causal explanations of behaviour. I do *this* or *that* to reduce tension (for Freud, true pleasure is to reduce tension, not to increase it), i.e. to release dammed-up energy. The concept of energy used by Freud, Fairbairn, and others is tied into their understanding of the biology of motivation. Freud chose to make sexual hunger his main motivator, terming it 'libido'. Others have continued to use libido as a general term, but have divorced it from its specifically sexual nature; Fairbairn is one of these. He writes 'The real libidinal aim is the establishment of satisfactory relationships with objects; and it is, accordingly, the object that constitutes the true libidinal goal. At the same time, the form assumed by the libidinal approach is determined by the nature of the object.' (Fairbairn, 1946a).

It is interesting to note the confidence with which Fairbairn claims to know what is 'real' – a style of over-confident and unargued assertion which is lamentably frequent amongst psychotherapy theorists. Perhaps he can be forgiven on this occasion, as he is here stating an important article of his beliefs – people are not primarily pleasure-seeking, but are orientated to relationships.

'Ego', as used by Strachey as a translation of Freud's 'Ich' ('I' in English), receives the longest entry of any term (14 pages) in the standard glossary (Laplanche & Pontalis, 1973). This reflects the confusion that surrounds it. At first blush, the Freudian model is simple – the infant is rotten with desires which are all either impractical or impossible. Fortunately, there are other people there to make sure that he or she is fed and watered, and there is time for the development of a reality principle which stands between the infant's desires and his or her actions. The infant learns about consequences, and how to anticipate them, as well as learning to reflect on itself and become self-aware. This is achieved by the development of a new 'agency' of the mind (modern developmental psychologists might call it a 'module') which is the ego. The ego becomes the executive which actually moves the limbs, attends to one sensation or another, brings memories into awareness, and thinks the thoughts. More importantly, the ego takes the impulses from the id, censors some ('repression'), turns others into a new channel, and lets a few of the more harmless ones through. What the ego lacks, however, is any energy of its own. Its operations are therefore energised by the very desires that it seeks to control. (Freud's later model of ego development is considered in the section below, under 'Identification'.)

Various objections to this model will occur to readers: one particular one is the place of self-preservation. Freud accepted that this was an instinct and therefore belonged to the id, that part of the mental apparatus which antedates the ego. However, it seems inconceivable that a self-preservative instinct could exist without some admixture of the reality principle. Infants who sucked their fingers in preference to nipples would hardly survive to an age when they had developed an ego. Putting it another way, it is inconceivable to imagine that at any stage, either phylo- or ontogenetically, an organism should have no adaptedness to its environment. Or, to put it yet another way, is the unconscious truly without a reality sense? When a patient of mine 'inadvertently' leaves out a love-letter from an illicit partner and the spouse finds it, I do not suppose that the attack on the spouse that this represents is devoid of reality, or that concealment necessarily serves self-preservation better than exposure. Rather, I suppose that the patient

was not able to accept that in being unfaithful, he or she had wanted to have some emotional impact on the spouse.

Laplanche (1992; Laplanche & Pontalis, 1973) suggests that the antithesis of the id and the ego only applies to sexual relations, since sexual desire can be completely dissociated from the reality principle. No-one would eat a PVC loaf, knowing it to be plastic, to satisfy a hunger for food. Plenty of people make love to PVC dolls or penises, knowing them to be plastic, and achieve sexual satisfaction thereby. This, it should be noted, is a quite different conception of the id from the one originally put forward by Freud. For Freud, the id was the animal inheritance, while the ego was the cultural artefact that was imposed on it as a control mechanism. In his unusual paper on the acquisition of fire, Freud mentions that civilization began when primitive man suppressed his urge to urinate on spontaneous fires and, instead, preserved the live coals to make more fires (Freud, 1932). Freud recognised that conflict is an essential feature of neurotic disorder and, less obtrusively, in how people generally behave. He attributed the conflict to the tension between the animal id and the social ego. This no longer seems sustainable. Animals are no less continent than people, and culture has made as great a contribution to the expansion of the range of desires as it has to the methods of suppressing them.

Lacan, who makes claim to have rediscovered the true Freud, suggests that the conflict between id and ego is more like that between desire (Lacan's '*l'imaginaire*') and its realisation (Lacan's '*le réel*'). I shall return to this antithesis when criticisms of how Fairbairn dealt with motivational conflict are considered.

Freud was quite vague about the genesis of the ego. Fairbairn evades this problem by supposing that the ego exists at birth and that the id (or, in Fairbairn's terms, the libidinal ego) is a later derivative of it. Fairbairn was therefore arguing that even the neonate shows discrimination and judgement, and orientates preferentially to potential care-givers. Klein was also of this view, but endowed the neonate with the capacity for abstract thought, which seems out of kilter with what else is known of the infant's cognitive abilities. She writes, for example, of the infant being filled with persecutory anxiety as a result of the birth experience and goes on to say that 'The infant's aggressive impulses towards the breast tend to turn it in his mind into a vampire-like or devouring object.' (Klein, 1952). Developmental studies support Fairbairn. They (Harris, 1994; Tantam *et al.*, 1993) suggest that infant brains are hard-wired to discriminate and respond to social cues such as eye-gaze or human voice, and that this results in the infant making a rudimentary but sufficient contribution to sequences of social interaction with care-givers from birth.

As in so many debates within psychotherapy, the difference between Fairbairn, Freud, Klein, and others is not empirical, but moral. Fairbairn rejected Freud's solipsism and Klein's demonic conception of the infant in favour of a child searching for security in a loving relationship: 'the greatest need of the child is to obtain conclusive assurance (a) that he is genuinely loved as a person by his parents, and (b) that his parents genuinely accept his love' (Fairbairn, 1952c). The unlikelihood of an infant, or even a child, thinking in these terms will be considered later. For the moment, it is worth noting that Fairbairn's emphasis on security is well on the way to a Bowlbian concept of attachment, and that his emphasis on shared loving anticipates the pre-eminence that Kohut gives to empathy in the development of a stable self. Indeed, there are many aspects of

Fairbairn's theory which seem to reappear in Kohut (see Robbins, 1992 for a discussion of this) although without acknowledgement (Sutherland, 1989). Not least is Fairbairn's conception of the ego, which is very like Kohut's 'self'.

Object, introjection and projection, internalisation and externalisation

Libido is not raw energy: it is the energy which drives a person to achieve some aim by means of interaction with some object. Sexual excitement can be discharged by genital stimulation by another person, or by one's fingers, or by rubbing on silk stockings. All of the latter – people, fingers, and silk stockings – can be 'objects' in the sense of being objects of a desire. Psycho-analysts tend to restrict the term 'objects' to people, and call other objects, 'part-objects'. The choice of the word 'objects' to refer to the other people that a person finds important is a disconcerting usage for a human science. Even policemen and private detectives call people that they are interested in 'subjects'.

Freud, and psychoanalysts who adhere to his approach, was more interested in the aim of a drive (his term) than its object. He distinguished sexual drives from self-preservative ones, and later life-giving from death instincts. Aggression was sometimes recognised as a drive, and sometimes as a consequence of the frustration of a drive.

The only objects that Fairbairn considered were the father, the mother, and metonymous representations of them or of their genitalia; and in this he is no different from most other analytic writers: the involvement of surrogate mothers in family life has hardly been recognised, and siblings as objects have received no attention at all. His use of 'relation' as, for example, in object relation is not a reference to social relationship, but to the third term which Melanie Klein interpolated between the aim of a desire and its object, which is the relation that the fulfillment of the desire mediates. Klein and Fairbairn both consider only two possible relations derived – by Ferenczi and Freud originally, presumably by a kind of sympathetic reasoning – from ingestion ('oral incorporation') and excretion. These were termed, respectively, 'introjection' or 'internalisation' (I shall not explore the nuances of meaning that distinguish these terms), and 'projection' or 'externalisation'.

These relations are of particular importance to Fairbairn's theory. He uses them to explain how the ego, and lines of tension in the ego, develop. Fairbairn writes that it is inevitable that the infant is frustrated by his or her mother. The infant deals with this experience by 'splitting the figure of his mother into two objects' but finds that, even so, he or she is still 'impotent to control' the experience as it remains in 'outer reality'. Then, Fairbairn writes: 'He [the infant] accordingly follows the only path open to him and, since outer reality seems unyielding, he does his best to transfer the traumatic situation to the field of inner reality, within which he feels situations to be more under his own control. This means that he internalises his mother as a 'bad' object' (Fairbairn, 1952a). Fairbairn goes on to speculate that this situation is hardly any better because 'he has introduced into the inner economy of his mind an object which not only continues to frustrate his need, but also continues to whet it' (Fairbairn, 1952b). This is resolved, Fairbairn supposes, by the infant splitting the internalised bad mother into a needed or exciting object (later to be called, the

libidinal object) and a frustrating or rejecting object (initially called the internal saboteur, and later the antilibidinal object).

Sandler and Perlow (1988) distinguish internalisation as a change in self-presentation, from its use by followers of Klein, of whom Fairbairn would certainly be one in this instance, to mean something concrete involving a change of 'structure'. The Oxford English Dictionary defines structure in a number of ways. The one that seems closest to this usage is 'an organized body or combination of mutually connected and dependent parts or elements'. Some have questioned whether the mind does contain bodies of this sort. According to Schafer (1987), structure 'is no longer taken seriously as a noun, an entity, or an essence'. However the word does connote solidity and phenomenal reality and, at the end of the day, this may be what Fairbairn meant. 'Internalisation' is a substantial mental change which endures.

One might go on to say that it is difficult to take 'introjection' or 'projection' seriously as anything but a fairy story to tell a patient. But even this is no mean claim. Cannibalism and magical birth feature prominently in myth; one need think only of the birth and demise of the gods of ancient Greece. People have eaten the flesh of particularly valued elders or enemies to imbibe some of their virtue. There is a kind of thinking – Freud called it 'primary process' thinking, which Klein placed under the head of 'phantasy', Frazer called 'sympathetic magic', and de Saussure 'iconic' thinking – in which this makes perfect sense. Klein's raunchy style, honed presumably in long conversations with young children, allows her to get away with writing in such metaphors. Fairbairn is much less successful; one is unsure whether he knew that he was using metaphor. I shall return to this later, when I consider how Fairbairn can be read.

Fairbairn's contribution, translated into the language of emotion

Fairbairn's major contribution was not to re-consider the definition of internalisation, libido, and the other terms defined above, but to use these traditional analytic metaphors in a new way. In this section, I shall try to describe this new way, but in the language of emotions rather than that of psycho-analysis.

Fairbairn's starting point was the nature of motivation. Some motives are appetitive: thirst is perhaps the most clear-cut example. A reduction in water intake leads to the intrusion first of a sense of thirst, then of demands for action to relieve thirst, then of preoccupation with water, leading to dreams about water or hallucinations of drinking. An adequate intake of fluid abolishes all these phenomena. Freud presumed that there was a sexual drive, similar to the thirst drive. This became blurred in the concept of 'libido' (a general tendency to activity), which was to be set against the 'death instinct' (a general tendency towards stasis). Klein presumed that there was an aggression drive, which was the core of the death instinct. Fairbairn rejected both concepts.

Whilst recognising that sexual and aggressive behaviour occur, Fairbairn considered them to be secondary to social relationships. These ideas were not very thoroughly worked out. Nowadays, if confronted by a violent man who had just beaten his wife, we might consider the following factors: his hereditary irascibility (possibly), previous exposure to violence in circumstances which encourage

imitation, current biological factors affecting irritability including intoxication, a violent response having been previously suppressed and consequently displaced onto the wife, something in the wife's behaviour triggering the violence, and the violence producing a desirable interpersonal result, e.g. feeling strong or getting her to lay off.

Fairbairn's focus was on what constituted a 'desirable' interpersonal result, and it was this which Sutherland considered 'Copernican'. Fairbairn shifted the psychodynamic orientation from models in which people were pushed by inner forces into doing things with other people, to a model in which people cannot help doing things with other people. In the traditional model, conflicts are primary, whereas in Fairbairn's model, inner tensions are created by the frustrations of social interaction. This model is therefore more parsimonious, since it starts from the uncontestable facts that people who are together interact and that, if the interactions continue over a period, they form relationships. Fairbairn does not need to posit pre-existing internal forces. His model has not quite escaped the adultomorphic characteristics of other psychodynamic theories of development, however. The infant seeks objects, has wishes, and experiences desires and frustrations. All of these actions imply intention, but considerable experimental evidence indicates that children do not use or correctly understand intentional statements until the period during which they develop a theory of mind, usually between the ages of 2 and 4. Purposive activity before that is strongly influenced by emotion, and many emotions are linked to characteristic actions: startle and running away, for example, or shame and hiding, or fear and running to mother, or anger and hurting.

It would therefore seem more consistent with current developmental psychology, and also with the social psychology of interpersonal relationships, if Fairbairn's theory could be recast without recourse to wishes or other intentional statements, but retaining goal-directedness. Using emotion terms as a method of unpicking social relationship is an obvious alternative and, indeed, Fairbairn did refer regularly to the feelings and actions associated with particular emotions. He concentrated mainly on love and anger, perhaps because they corresponded with libido and the death instinct. There seems no particular reason for excluding other emotions, however. Studies of attachment styles and temperament suggest that both anxiety and the disposition to anxiety are important influences on self-confidence and on the future development of relationships; other emotions may also be relevant.

Fairbairn considered that frustration leads to the other person being seen to be both good and bad, but that the child maintains the goodness of the other person by internalising the badness as a 'bad object'. However, this is a transient state because the bad object splits into two further objects, which are bad in different ways: one that is frustrating (the antilibidinal object) which leaves the infant experiencing 'a lack of love, and indeed emotional rejection' pp. 112-3], and one that is 'tempting or alluring' (the libidinal object).

Temptation and allurement are bad because, Fairbairn assumes, they imply a wish which will not be fulfilled. However if a person is certain that they cannot get what they want, the other person may be frustrating but is not alluring. Fairbairn is therefore referring to a situation in which there is a wish for a particular type of relationship, coupled with the hope that the wish will be satisfied. To keep this hope alive, the other person must reciprocate, if only tepidly. The

problem, therefore, is that the other person responds appropriately in kind – or else frustration would result – but there is a mismatch of intensity. Reformulating things using the language of emotion, it would appear that Fairbairn is referring to a situation in which the infant expresses an emotion directed to the other person, who responds with an appropriate kind of emotion, but not at an appropriate level of intensity. Fairbairn considers the situation in which the infant expresses love to the mother, and gets nothing back. In later life, a similar emotional mismatch might be recognised as longing and, although this is an emotion predicated on an intentional state which cannot therefore apply to the infant, it might serve as a convenient term.

Other mismatches in intensity were not considered by Fairbairn, but might be of importance in shaping emotional disposition and capacity for relationship. Anger expressed by the child towards a significant other person, most often the father, and a disproportionately *intense* response would be an example.

The other way in which an internalised object is bad is that it is rejecting. Love is met with irritation, anger with punishment, tears with rough handling. Putting this into emotion language, the response of the other person is inappropriate in kind, rather than in intensity. It is, however, likely to be rare that a person's response is mismatched only in kind, or only in intensity. The normal situation might be for there to be both kind of mismatches, occurring at the same time: for example, the over-anxious mother responds to a child's distress by an excessive reaction which includes fear as well as caring.

Fairbairn hypothesised that the bad, frustrating internal object is associated with a subsidiary ego which attacks it, and keeps it repressed. In addition, the bad object attacks the tempting internal object, leading to an intrapsychic conflict, to repression of the libidinal object, and to splits in the personality. It is known that infants react to unexpected emotional reactions on the part of mothers with a startle response, followed by withdrawal, i.e. with fear behaviour. It seems introspectively right to say that fear is also the reaction in adulthood when another person responds to an emotion with an inappropriate one, although an adult may then replace the fear with another emotion: anger, for example.

Fear thus functions as a self-regulatory emotion which is triggered when a prosocial emotion (separation-anxiety, anger, or love) is met with rejection. An intensity mismatch, when an emotion such as longing is met with indifference or a lukewarm response, is reported by adult patients to be a source of shame, rather than fear. Patients have reported to me that when they show strong feelings which others do not share, they feel as if they have been invalidated, or that other people think them out of control. Both of these are appraisals associated with shame. The behaviour associated with shame does seem to be acquired early on, and much of the experience of shame is hard to put into words, suggesting that it is pre-verbal. Mothers use teasing, mocking, or pretended indifference as methods of behavioural control with children; these responses are all associated with shame. It is in keeping with Fairbairn's work, I think, to posit a self-regulatory function for shame, with an especial link between shame and intensity mismatch.

Fear and shame (there may be other self-regulatory emotions, but I shall concentrate on these two) have a number of properties that fit them to function, as Fairbairn said that internal objects do. They both inhibit prosocial emotions – a process that corresponds to Fairbairn's notion of repression. Both fear

and shame are associated with avoidance or concealment. They both lead to rapid learning, generalise readily to related situations, and are easily evoked in anticipation. As a result, repeatedly experienced fear or shame can become entrenched and have a powerful effect on behaviour – a property that Fairbairn ascribed to internal objects.

Fairbairn was unusual in thinking that what is repressed is a part of the ego locked up with the internal object. The central ego, he wrote, maintained a relationship with its external objects in which frustration was kept to a tolerable level. An account of this in terms of emotion theory is that regularities in the feelings that a person might have for another person become elaborated into a disposition to feel certain ways and to want certain consequences from a particular class or group of people with whom one has a certain sort of relationship. The repressed internal object continues in relationship with the repressed subsidiary ego, Fairbairn further wrote. Putting this into the language of emotions theory, certain feelings are associated with a rupture in social relationship, the response to them is rejecting or inadequate, and this triggers a process of self-regulation in which the feeling is swallowed up by a self-regulatory emotion, such as anxiety or shame. Repetition of the sequence results in the self-regulatory emotion being evoked more and more promptly so that eventually the self-regulatory emotion is experienced in response to a disposition to feel in certain ways, i.e. in anticipation of the feelings which might lead to a rejecting or inadequate response. In consequence, these feelings are consistently avoided, and the disposition to have them becomes effectively hidden, along with the relationships to which that disposition might lead.

Fairbairn stressed the emotional inhibition associated with the schizoid personality, and attributed it to libido being used up in trying to attain the tempting inner object. The emotion account of this is somewhat more straightforward: self-regulatory emotions are linked to behavioural and emotional inhibition; if these emotions are evoked in many behavioural settings, there will be pervasive emotional and behavioural inhibition, creating an impression of emotional detachment. Inhibition is not the only 'defence' against self-regulatory emotions. With only a slight change in the eliciting stimulus, a fleeing animal may turn and fight, or collapse and play dead. Attack – often in the form of denigration, or shaming – may be a defence against the experience of shame. Fairbairn's developmental model has been criticised for being static. Klein envisaged a situation in which objects are internalised, projected, and re-internalised, with these cycles being repeated several times, each time changing the emotions elicited by the internal object. Empirical study of self-reports of shame incidents (Macdonald, personal communication) demonstrates that few incidents are associated with unmixed feelings of shame. The normal situation is that shame may lead to anger and this may lead to self-disgust, which may lead to sadness, and so on; secondary self-regulating feelings are then mobilised. Clinical practice often exposes feelings like this: rediscovering one feeling changes the situation and in the next session, some other connected feeling or relationship comes to the fore. A special kind of secondary self-regulatory feeling is sexual excitement, which can function to detoxify shame experiences which are re-enacted in a sexual context (Stoller, 1970).

Fairbairn distinguished between actions being inhibited by moral considerations from those that are inhibited by the effects of the subsidiary egos. He was clearly referring to the same distinction that Klein was alluding to in her contrast of the paranoid-schizoid and the depressive positions. I think that the emotion account translation of Fairbairn makes this even clearer, although it does mean introducing a new class of feelings: the compensatory emotions. These are more complex emotions than shame or fear, since their peculiar character is more strongly dictated by their central concern. Anxiety associated with a sense of guilt would be an example of such a compensatory emotion. Unlike shame or fear, guilty anxiety does not occur before an emotion has been translated into an action, and so inhibits it; it occurs after and appears to have the purpose of making reparation for the social consequences of the emotion or action.

How to read Fairbairn and other psychoanalytic writers

Reading object relations theorists, Fairbairn included, is a mystifying experience. Here are highly regarded, intelligent, and well-read people making assertions which strike the reader as verging on the nonsensical. Moreover, although they are generally unsupported either with independent evidence or with logical inference, they are stated with conviction. The difficulty arises because the reader – or at least, the non-psychoanalytic reader – is unclear what question the author is attempting to answer. The default question for many medical readers is, ‘How does the mind operate?’. Some of what Fairbairn wrote, but not much, is an answer to this question. If this were the most important question for psychoanalysts, then the work of Fairbairn and others would not be worth much consideration.

It is not the question that dominates patients who come to analysts. They want to know: ‘Why do I feel as I do?’, ‘What is the point of it all?’, and ‘How do I get better?’ A certain group of patients wants to know ‘Why is life so empty?’ Reading Fairbairn makes a lot more sense with this last question in mind, since it is the one that he seemed to want to find an answer to. However, knowing the right kind of answer to look for does not reduce Fairbairn and other psychoanalytic writers to clarity. The answer, if answer there is, is elliptical. I think this is a consequence of experience in the consulting room. Even patients who ask direct questions like ‘Why have I become depressed?’ give little attention to factual answers. What they want is to be relieved.

Sherlock Holmes’ first case turned on a message so damning that it gave James Trevor a fatal stroke (Conan Doyle, 1981). The message was: ‘The supply of game for London is going steadily up. Head-keeper Hudson, we believe, has been now told to receive all orders for fly-paper and for preservation of your hen-pheasant’s life’. Holmes’ intuition was that the message was nonsensical because it contained too much meaning. Explication required stripping two out of every three words, leaving ‘The . . . game . . . is . . . up . . . Hudson . . . has . . . told . . . all . . . fly . . . for . . . your . . . life.’ Holmes’ genius was to make something out of the remaining filler words. These were disproportionately drawn from field sports, and Holmes deduced that the sender of the message was therefore a landed gentleman,

to whom words like 'head-keeper' and 'hen-pheasant' would readily come to mind. Were Conan Doyle to have commented on this passage, he might also have said that the message had a burden which is distinct from its meaning, but arises because of the connotations of many of the words used in it. 'Fly-paper' conjures up getting caught like a fly on paper. 'Game', 'keeper', and 'pheasant' conjure up hunting, and being fattened up only to be shot in the end. 'Preservation' has the same connotation, but in addition means being preserved after death. The use of all of these words gives the passage a scary feeling which adds to the eeriness of the story as Conan Doyle tells it.

It may be helpful to think of the discourse in the consulting room and the discourse of the psychoanalytic essay as similar to the message to Mr. Trevor. There is just too much information. The scientific method is to throw away what is 'spurious' until there is a picture of – or, in this case a statement about – a state of affairs: 'Hudson has told all', for example. The analyst is interested in the apparently spurious because it has a flavour which conveys something about the patient's concerns and interests, and because it carries a burden of feeling. 'How have things been?' I said to an adolescent with Asperger's syndrome and congenital heart disease. 'Well, I'm not dead yet. I got very dizzy the other day, but it was just the heat. I think that I would have had a heart attack by now if I was going to have one, don't you?'. The flavour is physical illness, the burden is death and dying, but the overt message is that things are fine.

I think that these three strands of discourse can be discovered in psychoanalytic writing, including that of Fairbairn. Melanie Klein is a particularly effective user of connotative language: violent terms (biting, scooping out), references to biological functions, and upfront excretory terms carry a burden of feeling which has something of the liberation of being naughty in the nursery. The flavour of her writing, though, is pessimistic. Children are born full of rage and their relationship with their mothers is a battle for psychological survival. Fairbairn, on the other hand, is much less colourful in his use of language, and the burden of feeling is less heavy. Was this a deliberate policy? Was he attempting to restrict himself to pure statement? I also wonder if Melanie Klein's influence has partly come about because of her excellent rhetorical skills, whereas Fairbairn only comes alive when he discussed the schizoid dilemma. His language carries much less of the burden of feeling than Klein's, and for this reason fails to move its readers.

The flavour of Fairbairn led to two of his reviewers accusing him of wishing that his 'theory supplants that of Freud. If Fairbairn is right, then we teach Fairbairn and not Freud to our students' (Winnicott & Khan, 1953). Omnipotence was, for Fairbairn, one of the cardinal features of the schizoid personality; the two others were detachment and a preoccupation with inner reality. There is something of the flavour of them in Fairbairn's writing also. That developing a theory of psychotherapy is a work of personal healing, as well as of theoretical exploration, is uncontentious nowadays. Fairbairn's sympathy with the child, and his portrayal of its struggles to find expression of loving feelings towards others, may have been motivated by his need to deal with these problems in his own life.

That one is very conscious of an old-world flavour in Fairbairn's writings, and that one misses the excitement and colour to be found in other therapists who are more adept at manipulating the feelings of their readers, does not in the end detract from the message that he was trying to convey. Relationships that bruise and not comfort, turning away from further pain, and the insidious cost of the alienation of feeling amount to a predicament to which Fairbairn brought great sensitivity and understanding. I think – and have attempted to show – that his account of the phenomenology of this predicament remains of great value, not least because it is congruent with accounts of mental events couched in the language of emotions. Shame is the emotion that most characterises the Fairbairnian world. Shame, or shamelessness, also seems to be becoming an increasing preoccupation in *fin-de-siècle* European culture. Whatever it was that Fairbairn took from his private life that fired his interest in shame, he was able to transmute it into something that could not only be revealed to others, but be accepted and used by them. This is the challenge of shame: to reveal it, to accept the alteration of the self that results, and to stand by that alteration. Those of us grappling with this challenge in ourselves or our patients could do worse than look again at Fairbairn.

Acknowledgements

I am grateful to Emmy van Deurzen-Smith for many revealing discussions about the emotional issues surrounding existential dilemmas, and for helpful comments on an earlier draft of the chapter. My ideas about shame have benefitted from many discussions with James Macdonald.

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28 The Emigration of German Psychiatrists to Britain

UWE HENRIK PETERS

Hitler's rule over Germany had many devastating effects on German psychiatry.¹ One of them was that out of the approximately 3,000 German psychiatrists at the beginning of the Nazi period, about 600 emigrated – to all those countries which would permit them to come. This is the most important emigration movement in the history of psychiatry; there is virtually no parallel to it (Peters, 1992). After the United States, Britain was the second most important country of refuge, accepting about a hundred psychiatrists, but it was not the final country for all of them since some continued their emigration to the US or elsewhere.

It is well known that the immigration policy of the British Government before the second world war was very restrictive. There were only few exceptions; mainly domestic servants and 'distinguished persons, i. e. those of international repute in the field of science, medicine, research, or art'. In a considerable number of cases, psychiatrists were regarded as distinguished persons (Sharf, 1964) so that compared to other professions, it was not too difficult for them to come to Britain, though they still had to re-qualify in medicine.

Earlier German-British relations

The earlier history of the relations between British and German psychiatry goes back at least to the beginning of this century, when Henry Maudsley considered making an important endowment to establish what is now known as the Maudsley Hospital. Maudsley was also the main initiator of the German influence on British psychiatry; he took great interest in and was very well informed about both French and German psychiatric literature and institutions. As the promotor of his ideas Maudsley found Frederick Mott, who also looked for a closer contact with Germany and in 1907 travelled to visit Kraepelin in Munich, 'so that [I] may learn and adapt such information and knowledge'. After the visit, of which there is no published account, he recommended the creation of 'an Acute Hospital and Clinic for Mental Diseases based upon the German system' (Mott, 1921; Lewis, 1969; Meyer, 1973).

Mott was not the only British visitor to Kraepelin. Edward Mapother, who was to become the key figure in the early history of the Maudsley hospital and British psychiatric teaching, travelled to Munich in 1921, two years before the Maudsley

Hospital was inaugurated. Mapother (1926) published a highly positive account about his trip in a German journal, which, perhaps for language reasons, has escaped the attention of most British historians of psychiatry.

But equally Aubrey Lewis, who had learnt to express himself adequately in German, visited Germany – mainly Heidelberg and Berlin – in 1927, beginning a continuous contact with quite a number of the leading psychiatrists of the time. The correspondence concerning these contacts has remained unpublished up to now. Later (1963), Sir Aubrey Lewis published a biographical essay about Henry Maudsley in German, and this also included his views on German psychiatry in general. Lewis himself, of course, was an immigrant to Britain from Australia.

Classical and traditional psychiatry

When the forced emigration movement of German psychiatrists began in 1933, both sides – those who fled and those in the receiving country – took advantage of this situation. Among the first whom Mapother invited to come to London was W. Mayer-Gross who from 1933 to 1934 was a Commonwealth Research Fellow and from 1934 to 1939 Rockefeller Research Fellow, so that for six years, he had to accept a temporary situation. Alfred Meyer was able to come to London in 1933 with a visitor's visa and during his first years, with the help of various scholarships worked in the neuropathological institute of the Maudsley Hospital, which was then chaired by Frederik Lucien Golla, Mott having died in 1925. Also in 1933, Erich Guttman arrived in London and joined the group at the Maudsley; he came from Kraepelin's university department in Munich, but because of their age difference, had been in personal contact with Kraepelin for only a short time.

These psychiatrists – Guttman, Mayer-Gross, Aubrey Lewis, and Alfred Meyer – henceforth formed a stable group at the Maudsley Hospital, although Mayer-Gross moved away after six years. Another arrival was Rudolf Karl Freudenberg. In 1936, he was invited to introduce, together with his wife Gerda Freudenberg, insulin coma therapy to Moorcroft House, a private hospital. He was in close contact with the Maudsley group and after two years of preparation passed the medical examinations in Glasgow together with Mayer-Gross and Eric Guttman in 1939. Later, in 1951, he became medical superintendent of Netherne Hospital, which developed an outstanding rehabilitation service. Finally he was Senior Medical Officer and Head of the Medical Mental Health Section in the Ministry of Health, where he played an important part in the development of national mental health policy.

But what was the actual influence of this group on English psychiatry? Although Lord Taylor in 1962 wrote that: 'It is not too much to say that modern British clinical psychiatry is largely the product of the Maudsley Hospital' and the psychiatric teaching at the Maudsley in these years was primarily in the hands of the group mentioned above, this influence can be seen primarily in terms of organisation. What had fascinated Mapother and Lewis in the Kraepelin model was the combination of 'early treatment, research and post-graduate training' (Lewis, 1951), which indeed has remained as an ideal for many countries up to the present day. What was also appealing to them probably was the strictly biological and even common-sense orientation of Kraepelin's psychiatry. There was no problem for British psychiatrists in accepting Kraepelin's nosological

system, and the immigrants could win some influence so far as they met the needs of an already pre-existing structure in national psychiatry. On the other hand, the Heidelberg school of phenomenology (Jaspers, 1912), which had given the necessary psychological, or rather psychopathological semiology to Kraepelin's system, obtained practically no echo in Britain. Mayer-Gross, who in Germany had been one of the leading phenomenologists, and whose monograph (1924) on self-reports of confusion was generally considered to be the first and best monograph of the 'phenomenological school' (K. Schneider, 1926; Peters, 1985a), immediately stopped working in this manner after he had landed on British soil. Even in the textbook of psychiatry, which he published (1954) after his retirement, together with Eliot Slater and Sir Martin Roth – the leading textbook for a generation of British psychiatrists – there were only minor traces of phenomenology. Yet this movement was so essential for German psychiatry that it is still known as 'classical' German psychiatry. Mayer-Gross provided a great stimulus to research at each of the institutions in which he worked. Up to then, psychiatric research in Britain had been on an extremely small scale and was often of poor quality.

Apart from academic organisation, research, and teaching, the psychiatric immigrants also brought useful treatments to Britain, e.g. electroshock (ECT) and insulin treatment – then very new. In 1939, Lothar Kalinowsky came to Britain and, with the support of Linford Rees, introduced ECT, which he had learnt from Cerletti and Bini in Italy, his first country of refuge and after he had constructed the proper equipment in Paris, according to plans of Bini. But Kalinowsky was not allowed to work in Britain, and therefore continued his emigration a year later, to the United States (Kalinowsky, 1977). It is interesting to speculate what contribution he might have made to British psychiatry if he had been able to remain. As for insulin treatment, it was Gertrude May-Gross, who, as a student of Manfred Sakel in Berlin and Vienna and of Max Müller in Bern, introduced this then exciting treatment at the Maudsley and at St. Andrews Hospital in Northampton in 1939, at the request of Mayer-Gross in 1939 (personal communication by G. May-Gross). (Apart from this, May-Gross and Mayer-Gross had no activities in common). Two years earlier, the Board of Control had sent Dr. Isabel Wilson on a visit to Vienna and Germany to investigate the treatment (Wilson, 1936).

Apart from the better known Maudsley group, there were quite a number of other psychiatrists who contributed to the everyday psychiatric work of the country or of the Army after the outbreak of war. There was a severe national shortage of well trained psychiatrists, mainly because the subject had failed to develop in the medical schools, as it had in the German-speaking countries. Most doctors in mental hospitals had little or no formal training, so that the immigrants were an important addition to the national psychiatric cadre. Nevertheless, some German psychiatrists came to the country without being permitted to work in their profession. One of the outstanding collaborators of Kraepelin, Max Isserlin, arrived Britain in 1939, but could not work as a psychiatrist and died in 1941 in Sheffield, after an operation. His son, Benedikt Isserlin, now a retired professor of the University of Leeds, is still living in Britain.

An illustrative story is that of Max M. Glatt, who was born in Berlin in 1912. His father, an insurance agent, was a prominent member of the orthodox Adass

Yisroel congregation of Berlin, which had been founded after the Enlightenment to safeguard strict adherence to Jewish law. In Berlin, the congregation had its own network of schools, synagogues, hospitals, and a burial-place. In this educational network, Glatt received a traditional education in 1919-1930. The congregation was able to maintain itself in Berlin to some extent until March 1939. After medical school and residence with Karl Bonhoeffer at the Charité in Berlin, Glatt was able to work as doctor in the hospital of the Jewish community of Berlin, but in December 1938 was taken to the Dachau concentration camp. For reasons which are not clear, he was freed in February 1939, decided to emigrate to Britain, and got there with a visitor's visa in April 1939. Almost immediately, he was brought to the Kitchener Camp at Richborough, Kent. This had been opened by the British Government in January 1939 for 3,500 male immigrants, who had to wait there for the decision whether they would be permitted to remain or not. This stay was followed by another one of two and a half years in an interment camp on the Isle of Man. Finally, he was transported to Australia, but was able to return to Britain in the same year to do medical work, after a change in government policy towards refugees. First, he worked at Cane Hill Hospital in Coulsdon (1942-1944), then at St. Lawrence's Hospital, Caterham (1944-1951), and then at Warlingham Park Hospital (1951-1958), where he achieved the status of a consultant in 1958. It was only in 1952 that Glatt began the work which later gave his name an international reputation, when he founded the first British treatment unit for alcoholics. In the early 1960s, he established the first unit for the simultaneous treatment of alcoholism and drug dependence, and in 1973, at Wormwood Scrubs Prison, the first unit for drug dependents within the prison system. Glatt started writing about his experiences with alcoholics and drug addicts in 1954, and has subsequently published more than 500 papers and books. Rather than devising new treatment methods, he demonstrated a pragmatic therapeutic enthusiasm, and made use of all available techniques.

Others, however, only stayed for a number of years. Edward Krapf, who came from the university hospital in Cologne, was an early friend of Eric Guttman and came into close contact with Walter Maclay, Desmond Curran, and other members of the Maudsley group. Krapf passed his medical examinations in Glasgow in 1937, and was invited by Maclay to settle in Britain, but he preferred to go to Argentina, to be the Senior Consultant Psychiatrist at the British Hospital in Buenos Aires. Later, he was the second Director of the Mental Health Division of WHO in Geneva. His daughter, Eva Krapf, still lives in Britain.

Another was Karl Stern, who was able to work at Queen Square Hospital in 1936-1939, with a neuropathological scholarship. He later (1951) published a well known book entitled *The Pillar of Fire* about his experiences. During his stay in Britain, Stern converted to Roman Catholicism, and the profound importance of this to him can be seen in his book, *The Third Revolution: Study of Psychiatry & Religion* (1954). In Britain, he married Liselotte von Baeyer, sister of Walter Ritter von Baeyer, who became head of the psychiatric department of the University of Heidelberg after the second world war. In 1940, Stern continued his emigration to Canada, where he became professor of psychiatry at the University of Ottawa (1956) and psychiatrist-in-chief of St. Mary's Hospital in Montreal (1958), continuing in these posts until he died in 1975. Although the psychiatric immigrants were often distrusted and some had to pass many months or even years in internment camps as enemy aliens (Seyfert, 1983), they

tried to support Britain as far as they could. Some of them served in the British Army: out of the 25 immigrant doctors in the army, six were psychiatrists, all of them from Germany (Bentwich, 1950). One of the army psychiatrists was Eric Wittkower from Berlin. He came to Britain in 1933, was first a Research Fellow at the Maudsley Hospital and later lecturer in psychiatry, there and elsewhere. During the war, Wittkower became a major and 'worked out psychological tests for the selection of officers, which were adopted by the War Office Selection Boards' (Bentwich, 1950). Another immigrant psychiatrist was a Major Fisher, who became the Officer Commanding the military wing of a British Mental Hospital in India, but details about his life and work have been unobtainable. Jan Frank was clinical director of the psychiatric department of a clinic in Dublin in 1931-1935, then went to Prague and finally emigrated to Britain, where he became clinical director of Graylingwell Hospital, Chichester. Later (1946), he was to become a well-known psychoanalyst at the Menninger Foundation in Topeka, Kansas. A number of those who made important contributions later to British psychiatry came to Britain before they had become psychiatrists; notable among these were Heinz Wolff and Felix Post, the pioneer of psycho-geriatrics (Wilkinson, 1993).

Dr Samuel Last was born in 1902 within the Austro-Hungarian Empire, but qualified in Medicine in Berlin. He was then an academic neurologist at Bonn, before coming to Britain in 1934. After requalifying, he worked in mental hospitals at Cardiff and Northampton, moving to Runwell Hospital in 1936. In this progressive hospital, he did pioneering work on the clinical use of the electroencephalograph, establishing a research department there and at The London Hospital, Whitechapel. In 1951, he became medical superintendent of St John's Hospital, Aylesbury, where he initiated a programme of major improvements, while continuing his EEG and other research activities. After ten years, he moved to The London Hospital, where he remained until his retirement.

It should also be mentioned here that not a few of the women immigrants entered psychiatric social work (such as Matilda Goldberg), and some became psychiatric nurses, notably Annie Altschul. In both professions, they made a very useful contribution to the developments of the post-war period.

Stengel, a man between clinical psychiatry and psychoanalysis

Sir Aubrey Lewis said that: 'Stengel has only been singed' by psychoanalysis (Stengel, 1967). This probably holds true, since Stengel was not only considered by traditional psychiatrists as one of theirs, but also by the psychoanalysts. Undoubtedly, he was one of the most famous and successful of the psychiatric immigrants. Although his superb intelligence, Viennese wit, and 'verbal agility' (Jenner, 1991) were among his most frequently described personal characteristics, his life was overshadowed by the tragic events of persecution. However, in his personal communications to this author and autobiographical notes (Stengel, 1967), this background was not mentioned.

Stengel was a member of a family which came from the periphery of the Austrian Empire to its centre, and worked very hard there to establish a social position. In his Presidential Address to the Royal Medico-Psychological

Association (1967), Stengel emphasised that: 'The main reason why there was such a wealth of talent in the Klinik [the department of neurology and psychiatry of the University of Vienna] in the first three decades of this century was Vienna's position as the capital of central Europe up to the end of the First World War. Many of its professional people had migrated into the capital from the various parts of the Austro-Hungarian monarchy. There was a constant brain drain to Vienna.' What he did not mention, though, was that his father, Markus Stengel, had belonged to this group, and that his own life was deeply influenced by the same fact. But in a personal communication to me (1972), he made this point more clearly: 'My father was a Jewish teacher of religion in Vienna. He was born in 1860 in that part of Galicia, which now belongs to Russia, but emigrated as a young man to Germany, where he came under the influence of . . . Franz Delitzsch. . . . During this period, my father wrote poetry both in German and in Hebrew'. Delitzsch was a famous (non-Jewish) professor of protestant theology at Leipzig, who translated the New Testament into Hebrew; Markus Stengel published a book in Hebrew in 1884 to honour him. In 1942, Markus Stengel died in the Auschwitz concentration camp. Undoubtedly, the religious tolerance of Delitzsch continued to have an influence on Erwin Stengel himself.

Stengel's mother, Franziska Popper, who had twice given birth to a pair of twins, had already passed away in 1934. In Stengel's description:

I belonged to the second pair, which was born 14 months after the first. The twins were very unequal. My sister [Grete Wahl, born 1901], 14 months older than I, lives with her daughter, a doctor, in Australia. Her twin brother [Hans Stengel] died in Auschwitz. My twin brother [Guido Stengel] lives in New York. He had a modest position in a shop. (Stengel, Personal communication 1972. Original in German)

After medical school in Vienna, Stengel embarked on a traditional academic career; for 12 years (1926-1938), he was studying and teaching neurology and psychiatry in the University department. During this time, he published 53 papers on various, mainly neurological subjects. Simultaneously, he received instruction in psychoanalysis, but probably not very intensive, because he wrote

At the time when I started my psychiatric training, Freud no longer lectured, but there were regular seminars at his house, some of which I attended. I also had to report to him over a period about a patient of mine in whom he was interested. (Stengel, Personal communication 1972. Original in German)

Apart from this instruction, he 'had a training analysis lasting one year' first with Theodor Reik, who gave it up, and then with Edward Hitschman, but neither of these psychoanalysts has mentioned this, so that Lewis might have been quite correct in his witticism. In 1935, Stengel married the Catholic hospital nurse Anna Kohl, which became a happy marriage but remained without offspring. In 1936, he became *Privatdozent* (Assistant Professor) at Vienna University with a thesis on 'The relation between mental and speech disturbances', which was published as four separate papers in the following year. It is rich in clinical observations, in the aphasiological tradition of the Vienna school, particularly of Otto Pötzl, his academic teacher (see Pötzl, 1925, 1930). In 1938, Stengel was forced into emigration – what he called in 1967 a 'hurried departure from

Vienna', but did not describe in detail. But there is a vivid description in the memoirs of the Swiss psychiatrist Max Müller, who visited Stengel at that time.

It was a terrible hour which I passed there [in Stengel's home]. The apartment was completely emptied out; everything was packed into boxes. Both of them [Erwin and Anna] were sitting pale and full of anxieties on their boxes and said the only question would be, what would be first, either the visa or the Gestapo. Both were equally uncertain. The visa could arrive today, tomorrow, or the day after; the Gestapo could be there in the next minute. Both adjured me to leave immediately. If I was met in the home of a Jew, I would be arrested also and would face terrible things. . . . The conversation dragged along in a fatiguing way; basically, everyone was thinking his own thoughts, unable to make real communication. In addition, the Stengels were deeply tired, sad, and ridden by fruitless waiting. (Müller, 1982; original in German)

Fortunately, the visa was first and was made possible by the Society for the Protection of Science & Learning, a British organisation established in 1933 by Lord Beveridge to aid and find positions for scholars dismissed from German universities.

After his arrival in Britain, Stengel immediately changed his language, and when Müller met the Stengels for the next time in Paris 12 years later, they almost felt unable to speak German to him. It is interesting that the second paper which Stengel published in Britain was 'On learning a new language' (Stengel, 1939). But he had also to learn medicine again, and as an enemy alien came into one of the internment camps in 1940 for four months. According to Jenner (1991), Stengel, stimulated by Edward Glover, wrote an (unpublished) account 'Considerations on some experiences during a short period of internment', in which he enthusiastically praised the administration of the camp. Finally, he received the Scottish qualification and in the following years worked in Bristol, Exeter, Edinburgh, Dumfries, Chichester, London and Sheffield. From 1957 until his retirement in 1967, he held the newly created chair of Psychiatry at the University of Sheffield. In 1954, Stengel became president of the Medical Section of the British Psychological Society and in 1967 was the last President of the Royal Medico-Psychological Association. With his assistance, this evolved into the Royal College of Psychiatrists in 1971.

It was only in 1948 that Stengel began, together with a number of colleagues, to publish work about the problems of suicide and suicidal attempts, which made him an international authority in this field of psychiatry. For two decades, he tried with questionnaires and in other ways to establish some solid data. The results were not particularly surprising, but provided him with the background of experience, which allowed him to participate in the legal reforms which occurred during these years. It is interesting to speculate whether his concern for the question of suicide had something to do with his own life experiences, as it had for such well known persons as Arthur Koestler, Primo Levi, Bruno Bettelheim, and Jean Améry (Peters, 1991). The Vienna-born writer Jean Améry (real name: Hans Mayer), emigrated in 1938 to Belgium, but was captured by the Nazis there. He survived the concentration camps of Auschwitz, Buchenwald, and Bergen-Belsen and, after a number of more or less successful biographical books, published in 1976 *Hand an sich legen – Diskurs über den Freitod* ('Make away with oneself – a discourse on suicide'), in which he praised suicide as the utmost

form of freedom. Two years later, he ended his life by his own hand. It would be understandable if Stengel had had such ideations and turned these into scientific endeavour, but in his known writings he did not allude to anything of this kind.

After retirement, Stengel returned to Freud, though the preanalytical figure. He had translated Freud's book on aphasia into English and commented on it both in English and in German (1954a,b), but he now prepared an edition of Freud's anatomical and neurological writings in three volumes and wrote a preface to it (personal communication). However, these volumes still await publication (communication from the Sigmund Freud Copyrights).

Concerning his Austrian roots, Stengel's emotions remained mixed. In his communication to this author in 1972, he wrote:

My relations to my Austrian homeland, which I as a Jew had to leave in 1938, are slightly cold but not unfriendly. My wife has relatives in Carinthia, whom we have visited twice since the war. Ten and 15 years ago, I was in Vienna twice to attend congresses, but I made my sojourn there as short as possible. I could not forget the Austrian enthusiasm for Hitler. Looking back, I have to say that I never felt at home in my native country, even before Hitler. Vienna was particularly antisemitic. (Original in German)

Psychoanalysis

The history of British psychoanalysis has been written more than once, but rarely from a general viewpoint (Dare, 1976; Pines, 1991). It has been more often from a very personal viewpoint (Glover, 1949; Schmideberg, 1971), and sometimes from very specific ones (Scott, 1949; Gillespie, 1963; Kohon, 1986). In these accounts, the history of the discussions, power struggles, and splits in the analytical community seem to be more important than psychoanalysis itself. Phyllis Grosskurth's biography of Melanie Klein (1985) is very informative in many respects about these events.

However, there is no specific study of the German psychoanalysts in Britain or in the British Psychoanalytical Society. The number of immigrant German psychoanalysts has been given as 36 by Kohon (1986), but these were only the members of the official British Society, not counting the Jungians and other analysts. Probably, the German analysts never felt themselves to be a discrete faction, either inside or outside the Society. They were mostly Anna-Freudians, Kleinians, independents, etc., just like the rest, so that it remains a difficult task to follow their activities and identify their influence.

It is striking that English philosophy and psychiatry have been such as to largely exclude the general acceptance of psychoanalysis. Therefore, it is not surprising that there were so many, and sometimes such bitter attacks against it. In itself, the British tradition of fairness and tolerance would not explain why a relatively independent and creative psychoanalysis in Britain developed relatively early, if small and restricted to a certain sector of culture and society. This remained so, even though psychoanalysis never had the broad influence on culture and medicine that it had in Germany and the United States, as well as much later in France and Italy. The reason for this might perhaps be that in Germany, the dynamic psychiatry which developed before and in the time of Mesmer –

which psychoanalysis always consciously or unconsciously depended on – had strong influences from Britain (Peters, in print). Sterne's *Sentimental Journey Through France and Italy* (1768) was translated immediately into German and became the basis for the emotional temperature of the Romantic movement on the European continent. Its influence there may well have exceeded that in Britain itself, where the age of sentimentality was perhaps not seen as such, whereas the Romantic movement in Germany absorbed, enlarged, and expanded early psychodynamic psychiatry. Thus, not only were the writings of John Brown and his biography, written by his son William Cullen Brown, translated into German, but it was Andreas Röschlaub's German translation (1806/07) which caused a more general reception of – as well as resistance to – Brown's theory on the European Continent, e.g. in Italy. Out of the Brownian theories, a technique was derived for humane management and treatment in the first psychiatric institutions, which were founded solely for therapeutic purposes. The reception of Brownianism was not only in philosophy (Schelling, 1799; see also Risse, 1970; Hegel; see Bole, 1974) and literature (e. g. Kotzebue; see Wiesing, 1990), but also in medicine. This was mainly through Adalbert Marcus, the founder of the first psychiatric hospital in a modern sense of the word in 1804 at Bamberg (see Marcus 1797-1799, and 1802-1806). Ever since that time, in spite of the warnings of scientifically orientated psychiatrists, a certain interest in Brown's achievements has continued in Germany (see Henkelmann, 1981), because even during the climax of positivistic, 'scientific' psychiatry during the last five decades of the 19th century, dynamic psychiatry never really died out.

Therefore, perhaps this background can help to explain some important aspects of psychoanalysis. One of these is that its reception in Britain jumped over an important language barrier; the German language has only rarely been spoken as a second or third tongue west of its linguistic borders. Yet a constant stream of English psychiatrists travelled to Vienna and Berlin, in order to come into direct contact with Freud and his followers (Pines, 1991). James and Alix Strachey devoted 25 years of their lives mainly to the translation of Freud's writings into English – a commitment, which must be unique. In spite of the many shortcomings of this translation, which are irksome for the scholar of German cultural history (see e.g. Bettelheim, 1983), this translation continues to be the basis for the study of Freud in the English-speaking global community.

Freud himself chose Britain as the country of his refuge, when he could no longer avoid emigration. It was then his intention that London should become the centre of psychoanalysis, once Vienna had been left behind, and from the time that Freud arrived in London, the language of psychoanalysis switched from German to English. Together with Freud himself, his immediate family and a large group of personal friends and other relatives came to Britain. Anna Freud, whose life was divided by the emigration into two equal periods, started her second, international psychoanalytic career from the London base. Finally, it was an Englishman (or rather Welshman), Ernest Jones, who wrote the first comprehensive biography of Freud.

With all of these factors, the German-speaking psychoanalytic immigrants might have been expected to have developed an overall influence on British psychoanalysis and psychiatry. But in fact, nothing happened in Britain that could in any way be compared to the psychoanalytic decades in America. The Viennese group was respected and accepted, but remained somewhat isolated.

However, there was one important group which was closely connected with Sigmund, Martha, and Anna Freud. Anna Freud founded her own independent institution, and was the training analyst for a significant number of psychoanalysts, but without describing it as such (Peters, 1985b). Freud's son Martin (Jean Martin), who was a lawyer, had been a member of the psychoanalytic association in Vienna because he was responsible for the *Internationale Psychoanalytische Verlag*. He also became a member of the British Psychoanalytic Society, although he did not practice analysis. In 1940, he was also interned as an 'enemy alien', and afterwards remained close to the family and to psychoanalysis. Through some of his writings (M. Freud, 1958), he became a source of knowledge about the life and history of the Freud family; he died in 1967 at Hove, Sussex.

Ernst Freud (formerly Ernst Halberstadt) also went to London with the Freud Family and spent the greater part of his life there. Currently, he is the only practicing psychoanalyst from the Freud family, his orientation being that of Anna Freud. He is the son of Freud's daughter Sophie, who had died during the influenza epidemic in 1920. His brother Heinele died as a child, in Freud's home in Vienna, from tuberculosis. With Anna Freud came also Dorothy Burlingham and her children; they had been together in Vienna and remained so until the end of Dorothy's life. There was also the housekeeper, Paula Fichtl, a well known person in psychoanalysis, who published her own memoirs in association with Detlef Berthelsen. She returned to live in Vienna only when she became very old. Close to Anna Freud, but at the same time retaining a certain distance, was Josephine Stross, a paediatrician, who was Freud's doctor during his journey from Vienna to London, and a member of both the Vienna and the British Psychoanalytical Societies, although she never practised psychoanalysis. At the end of Anna's life, after she had a stroke, Dr. Stross moved to the Maresfield Gardens house and helped to nurse her. She had been needed as Freud's personal doctor only because Max Schur was at that time suffering from appendicitis. Schur followed a few days later to London, but remained there only until Freud's death (September 23rd, 1939) and then emigrated to the US. His famous book about the life and death of Freud (1971) was not appreciated by Anna Freud because in her opinion it abused confidentiality, and she never read it (Anna Freud, personal communication). Other immigrants included Nelly Wolffheim who came to Britain in 1939, Hedi Schwartz, Maximilian Steiner who came to London in 1938 and died there in 1942, and Barbara Lantos, née Ripper, who lived and worked in London until her death in 1962.

The Hoffer couple – Willi (Wilhelm) Hoffer and Hedwig Hoffer-Schaxel – belonged to the closest circle of friends and supporters of Anna Freud in London. Except for obituaries, no extended appreciation of their lives and work has been published and will probably only be possible after access to more of their letters and diaries becomes available. The Hoffers came to London with the Freud family, and remained even when they received invitations in 1940 to go to the US, where perhaps they would have been able to have a more independent and influential position. Wilhelm Hoffer was born in September 1897 at Luditz, a small town in Bohemia, then long part of the Austrian lands. His wife, Hedwig, who was born in Munich, belonged to the well educated bourgeoisie. Both had had previous early marriages, which ended with divorce. Hedwig, née Schulmann, was first married to Professor Julius Schaxel of Jena, had published under this married name, and therefore later kept the name Hoffer-Schaxel.

It was the Baumgarten Nursery in Vienna, which brought her and Hoffer together. These nurseries only existed from August 1919 to April 1920, but in this short time developed a far-reaching influence. Founded by Siegfried Bernfeld, they successfully resocialised 300 of the 20,000 Jewish children, who were then living homeless and without parents in South-East Europe. Later, the Baumgarten served as a model for Anna Freud's Hampstead Nurseries in London.

Hedwig was analysed by Anna Freud, and Wilhelm by Herman Nunberg, which certainly helped to keep them close to the inner circle. Willi later worked in private practice in London and was consultant to the Hampstead Nurseries and the Maudsley Hospital. Following his early interests – in 1922 he had earned a PhD with a thesis in pedagogics – the early development of personality remained at the centre of his attention. Hoffer was one of those psychoanalysts who actively contributed to the reconstruction of psychoanalysis in Germany after World War II. Hedwig became a training analyst of the British Psychoanalytical Society, and died in London in 1961. Willi died in 1967, also in London, when he was President of that society.

Other psychoanalysts who went to London together with Freud were Marianne and Ernst Kris. Ernst Kris became a training analyst of the British Psychoanalytic Society and during the war, worked for the BBC, analysing Nazi propaganda. After the death of Freud, he moved to the US, where he continued to work for the BBC and later became one of the best known American psychoanalysts. Marianne Kris, a well known psychoanalyst and one of the editors of the *Psychoanalytic Study of the Child*, followed the same route after the death of Max Kris in 1957. She died in 1980 in London, while staying at Anna Freud's house in Maresfield Gardens in order to attend the seminars of the Hampstead Clinic.

Working closely together with Anna Freud both in the British Psychoanalytical Society and in the Anna Freud Clinic were Ilse Hellmann and Paula Heimann. The latter belonged to the supporters of Melanie Klein for many years, but then completely broke with her (see Grosskurth, 1985). Ilse Hellmann, on the other hand, always supported Anna Freud. There was also Eva Rosenfeld, who had come to Britain in 1936, two years before the Freuds. She had been an intimate friend of Anna Freud – for a number of years virtually her alter ego – and was analysed by Sigmund Freud after she had lost three of her four children. But this friendship faded when Dorothy Burlingham appeared and took over her place. From early childhood, Anna Freud had only one very intimate female friendship at any given time and dropped this when her heart was taken by someone else. In Britain, Eva Rosenfeld continued her analysis with Melanie Klein and tried to take a position between the two women, which of course, failed. Peter Heller, who also emigrated to Britain in 1938 as a pupil of the Rosenfeld school and analysed Anna Freud, belonged to the psychoanalytic group; he did not become a psychoanalyst, though, but a professor of German and comparative literature. In 1944-1951, he married Katrina Ely Burlingham, the daughter of Dorothy Burlingham. Heller published Anna Freud's letters to Eva Rosenfeld, and in this book, Viktor Ross, the only surviving child of Eva Rosenfeld, who had emigrated together with her to Britain and later was in charge of the English edition of *Reader's Digest*, published a short but vivid biography of his mother.

In the other camp there was Melanie Klein with her family and followers; both her surviving children emigrated to Britain. Her daughter Melitta Schmideberg,

who had come with her husband Walter to Britain in 1932, was later in the US for some time, but then returned to Britain. Both Schmidebergs were psychoanalysts, Melitta having already had her first training when she was living as a young girl with her mother in Budapest. A very learned and witty woman, she later turned away from her mother's teaching, of which she gave a vivid account (Schmideberg, 1971), and the two became personally estranged. Melanie Klein's son Erich, who anglicised his name into Eric Cline, had been analysed by his own mother – of which she published an account – but stayed away from psychoanalysis. The most extensive account of the followers of Melanie Klein has been given by Phyllis Grosskurth (1985).

Among the most prominent independent psychoanalytic immigrants were the Balints. Born in Budapest, where he studied medicine, Michael later moved to Berlin, won a PhD, and was an analysand of Hanns Sachs. Balint was not only a doctor, but also a comparative linguist and biochemist. In 1939, Balint came together with his first wife, Alice, to Manchester. Alice was a psychoanalyst's daughter and herself a student of Ferenczi and Róheim, and later one of the first candidates of the Berlin Psychoanalytic institute. She became an ethno-psychoanalyst, concentrating on the mother-child relationship. She died in Manchester in August 1939, only 41 years-old. The first Balint groups were founded at the Tavistock in 1949, and from there, began their way around the globe. Some of the many books and papers which Michael Balint published are now part of the standard literature in psychiatry.

Independent even from the 'independents', although a member of the British Psychoanalytical Association, was Siegmund Heinrich Fuchs (better known as S. H. Foulkes), who was among the first of the Berlin group to arrive in Britain in 1933. His later international reputation was based on his work in group psychotherapy. This new therapeutic method was first developed by him in an Army psychiatric hospital at Northfield in 1942 and in many respects was an important basis of the new 'therapeutic communities' (see Millard, this volume). Foulkes not only had a psychoanalytic training in Vienna as well as in Berlin, but was deeply influenced by Hegelian philosophy and the holistic approach of the neurologist Kurt Goldstein (who published his principal book *The Organism* 1934, during his emigration in Holland). Foulkes himself saw the origin of his group work in the time when he was working with Goldstein (Foulkes, 1974; Pines, 1979). After the war, Foulkes worked in private practice and concentrated on teaching group psychoanalysis and psychotherapy at St. Bartholmew's Hospital, at the Maudsley, as well as in many foreign countries, including Germany.

However, this list does not mean that psychoanalysts of the orientation of Carl Gustav Jung and Alfred Adler were not represented among the immigrants. Alfred Adler himself had died in Aberdeen in 1937, when he was on a lecture tour, having emigrated to the US in 1935. After this unexpected death, his daughter Alexandra Adler continued the tour. One of the most active Adlerian psychotherapists was Joshua Bierer, known mainly as the founder of the day hospital in 1947. Born in 1901 at Radautz in the Austrian crown land of Bukovina, which is now part of Romania, Bierer came to Vienna in 1926 to study with Alfred Adler and Alexander Neuer. At the same time, he was a student of the university of Berlin, but subsequently becoming a resident at the psychiatric department of the University of Vienna. In 1938 he emigrated to Britain, where he worked at Runwell Hospital, Essex (1939-1943), and Guy's

Hospital in London. Bierer then joined the British Army (1944-1946), in which he held the rank of major. Bierer criticised Freudian psychoanalysis sharply, but also wanted to see the abolition of the mental hospital as well as believing that the modern prison system encourages criminality. All of this, in his opinion, could be replaced by self-governing therapeutic communities – an ironical position, in view of his authoritarian temperament.

Wilhelm Stekel was forced into emigration at the age of 70 and chose Britain, where he arrived in 1938 already an ill man. He then wrote most of his autobiography (Gutheil, 1950) and on June 25, 1940 committed suicide in a London hotel.

Jungian analytical psychology had had a number of early English followers (Prince, 1963; Fordham, 1977). Some, like H. G. Baynes, went to Zürich to be close to Jung. C. G. Jung himself had started in 1928-1930 to give seminars in English in Britain, continuing there in 1933-1939. Following the example of the Freudians, a British Society of Analytical Psychology had been founded. Jungian psychology in Britain developed more strongly, when the continental immigrants arrived, but not many details of this are available. James Kirsch, who emigrated from Germany to Britain in 1935, was said to have been one of the very first Jungian psychotherapists in Britain. His private practice was flourishing in Harley Street, London until 1940. But he then decided to continue his emigration to the US, because the war was coming closer (Personal communication). His son Thomas Kirsch, now a well known Jungian psychotherapist in Palo Alto, California, was born in London. Gerhard Adler, a key person of the Jungian movement, who was born in Berlin, and was to play a very important role later in the publication of the Freud-Jung letters, came to Britain in 1936.

Conclusion

The material of this chapter strongly supports the view that the immigration of 1933-39 was almost certainly the most important influx of foreign psychiatrists which Britain has ever had. Yet the fact that this has not previously been examined historically is understandable. The German immigrants did not identify themselves at any time as a separate group. In fact, they only communicated with each other when they were members of the many subgroups, which were the same that British psychiatrists also belonged to. Their wish was to integrate into British professional life – a task in which they succeeded to a surprisingly large extent. The German immigrants also included many younger people – some only children at the time – who would later become psychiatrists, and some of whom would attain distinction in that role.

Acknowledgements

The author wishes to acknowledge the assistance and help of many persons who gave him very useful informations. Quite a number of them have already passed away. Out of the great number, he wishes particularly thank those who contributed with informations particularly to this paper: Rudolf Karl Freudenberg, Lothar Kalinowsky, Gertrude May-Gross, Benedict Isserlin, Max Glatt, Eva Krapf,

Eric Wittkower, Erwin Stengel, Max Müller, Melitta Schmideberg, Eric Cline, Anna Freud, Ernest Freud, Ilse Hellmann, Paula Heimann, Josephine Stross, Herbert Ross, Alexandra Adler, and James and Thomas Kirsch.

Notes

- 1 'German' is being used here in the traditional sense, referring to a unity of language, history, and culture that someone belongs to, without reference to any political entity or to frontiers.

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29 Maxwell Jones and the Therapeutic Community

D.W. MILLARD

Maxwell Jones was born in Queenstown, South Africa in 1907 and died in Nova Scotia on 19th August 1990. Although his influence was by no means confined to Britain, it emerged powerfully and principally from his work in two British institutions – a unit at Belmont Hospital, Surrey (later to be known as the Henderson Hospital) where he practised from 1947 to 1959, and Dingleton Hospital on the Scottish borders (from 1962 to 1969). But there exists a story both prior to and following those experiences. He was the leading apostle of the therapeutic community at a period in the history of British psychiatry when personal charisma counted more than rigorous scientific research as the engine of psychiatric advance.

History is never tidy, but it seems possible to organise this chapter into four phases. First, I shall comment briefly on Maxwell Jones' career before the 1939-46 war and before the therapeutic community. Second, I shall consider developments during the war and the immediate post-war period when the principles of the therapeutic community were first explored. The third will describe Jones' period at the Belmont when these principles were brought to maturity, and briefly survey the subsequent fortunes of the therapeutic community movement. The fourth phase covers a broadening of Jones' personal contribution, including his work at Dingleton and beyond. Within each, I shall set the man into context – in the belief that it is good history, good psychiatry, and indisputably crucial to therapeutic community practice always to attend equally to the individual and the social environment in which he or she is operating.

The earlier years

Maxwell Jones, almost universally referred to as Max, several times briefly described his own background in print. His 'gifted and liberal' (Jones, 1952) family originated in Northern Ireland and were engaged in education or religion, but his parents emigrated to South Africa towards the end of the nineteenth century and the family lived near Mafeking until Jones was five, when his father died. William Wilson Jones, a schoolteacher, was apparently popular, gregarious, and drank too much (Murto, 1991). After his father's death, Jones' mother brought Max and his two older siblings to be educated

in Scotland, where he attended Stewarts College and later Edinburgh University. Of his schooldays, he chose to mention matters of which echoes emerge later: 'terrified of what seemed to be unnecessarily harsh discipline and a feeling of confusion and outrage at the use of corporal punishment'. On the other hand, he became captain of school rugby and 'learned at first hand and for the first time the importance of group morale and purpose, of personal relationships and of leadership'.

'I suppose I had something of my father's roving spirit' he told Barraclough (1984), in the course of explaining his wish as an 18-year old to become a Kenyan coffee-planter. Frustrated by failing to raise the £2,000 then required to enter the government training scheme, he settled for his 'second love, which was psychiatry - the idea of knowing people'. He reports a schoolboy interest in reading some of the great novelists of human character - the Brontës, Dickens, Dostoyevsky - and of being influenced by reading William James' *The Varieties of Religious Experience* (Murto, 1991) - but no-one seems to have identified any other factors contributing to what in 1925, and in the absence of a family background in medicine, must have been an unconventional and uncommonly specific career choice. However, Jones was always quite clear: 'I slogged through medicine in order to become a psychiatrist. It wasn't a love of medicine at all, just an interest in people' (Barraclough, 1984). He was not a distinguished medical student, but a long-term colleague (Tuxford, 1991) notes a particular interest in physiology which reappears in his work as a young researcher.

After qualifying in 1931, five years were spent at Edinburgh acquiring a training in psychiatry and in research under Professor D. K. (later Sir David) Henderson. The influence then predominating at the Royal Edinburgh Hospital was Meyerian psycho-biology, although both Henderson's work on *Psychopathic States* and the influential *Textbook of Psychiatry* (with R. D. Gillespie) also give a good deal of emphasis to the social dimension. But Jones set off on a series of investigations into the biological correlates of neurosis. He worked on carbohydrate metabolism and enzyme chemistry, and his early papers deal with acetyl choline and choline esterase in relation to anxiety and depression as well as with a variety of endocrinological studies in psychiatric disorders. This work was split between Edinburgh and the United States. Jones had become a lecturer in Henderson's department, but in 1936 obtained a Commonwealth Fund Fellowship to spend a year at the University of Pennsylvania and a second year at Columbia Medical Centre, New York. Henderson had of course been greatly influenced by his experience at Baltimore with Adolf Meyer, and Jones' relationship with transatlantic developments in social psychiatry was to become similarly close. Four of his seven books (1952 to 1988) were published in the United States. However, during this period his research was entirely laboratory-based, and it was his intention to continue animal work on his return to Britain.

It was on the basis of this career in biological research that Aubrey Lewis recruited Maxwell Jones in 1938 to the staff of the Maudsley. This move was of some historical significance, for it placed Jones within the psychiatric establishment - and thus in a position where later he was to be both protected and influential - and it provided almost directly the setting for his earliest work in the very different field of social psychiatry. Initially, he became interested in physical treatments and published a couple of papers on insulin therapy

in schizophrenia. But by this time, the life of the nation was dominated by the threat of war. A Royal Medico-Psychological Association memorandum of about this time had predicted (pessimistically, as it turned out) that the outbreak of war would be accompanied by high levels of psychiatric morbidity, and psychiatric institutions were being prepared in various ways for the onset of hostilities.

Under the threat of air raids, the Maudsley Hospital was evacuated from its inner city location to form Emergency Medical Services (EMS) hospitals on two suburban sites. Part went to Belmont Hospital, Surrey and part, including Walter Maclay (as director), Aubrey Lewis, Eric Guttman, several of the more psychotherapeutically-orientated staff, and Jones himself, to Mill Hill where they occupied the premises of the public school, itself evacuated even further afield.

With his interest in psychosomatic disorder and psychosomatic research, Jones was placed there in charge of a unit to deal with Da Costa's (or Effort) Syndrome. He remained in that setting for about five years, during the earlier part of which he was able to combine clinical responsibilities with continuing research. Working with the distinguished cardiologist Paul Wood, Jones established biochemical indicators associated with the syndrome of left-sided chest pain, breathlessness, giddiness, etc. Despite the prevailing vicissitudes, three or four papers were published on this work between 1940 and 1942, and Jones was able to write it up for his Edinburgh MD (obtaining thereby the first Gold Medal ever awarded for a psychiatric topic).

Prodromata of the Therapeutic Community

The clinical basis for this work was a unit of 100 beds, through which passed a succession of military personnel. At first (in 1940), the wards of the Effort Syndrome Unit were indistinguishable from those of a general hospital, as was the regime and the roles of the nursing staff. However, these matters were to change.

The earliest report of this work (Jones, 1942), having described the psychiatric background of patients with cardiac neurosis, refers to attempts during the first two years to treat it with individual psychotherapy 'under rather difficult conditions' including the pressure of a large number of cases on a small staff. Thus 'it was decided to try a form of group therapy. . . . The treatment was tried on a group of 50 patients, the remaining 50 being given individual psychotherapy'.

There were three meetings a week, at 9.00 am on alternate days; the patients and the doctor were seated comfortably, the whole atmosphere being completely informal. The junior nurses working on the wards sat at one end of the room. An educational format was used and 'the talk lasted on an average 20 to 30 minutes with a quarter of an hour at the end for open discussion'. Jones' teaching model presented three levels of CNS activity – cortical (roughly the equivalent of consciousness), thalamic ('un-differentiated emotion') and brain stem (control of visceral nervous activity) – through which the patients came to learn something of psycho-somatic mechanisms. There was some attempt in practice to avoid the use of the phrase 'effort syndrome' (Crockett, personal

communication). The other large emphasis was on the development of group responsibility, which in this military situation was thought of as closely linked with morale, as involving (like a rugby team) some sacrifice of individual wishes in the interests of the immediate group, the war effort, and indeed the nation as a whole.

The attempt at a controlled trial implicit in the foregoing description came to nothing, but Jones reported 'impressionistically, the results so far have been far better than with any other previous method', with the virtual disappearance from ward conversations of a preoccupation with heart disease, and a rise in the number of men returning to Army duty to a higher level than at any time since the unit had started, two and a half years before.

By 1944: 'Since . . . 1942 we have greatly widened the scope of our methods' (Jones, 1944). Patients were being seen in groups of about 90, only one-third of whom by this time had Effort Syndrome, the remainder having anxiety states or depression and being 'the more chronic constitutionally endowed material, the 'better' neuroses going to the military neurosis centres'. Ward groups met thrice weekly from 9.00 to 11.00 am and continued to follow an educationally based syllabus of 12 topics. An increasing reliance was placed on discussion among patients, and staff were able to 'set the goals and let the men work out a solution for themselves with the minimum of help.' Verbatim accounts of two such sessions are preserved in *Social Psychiatry: A Study of Therapeutic Communities* (Jones, 1952, pp. 4–12).

The common rooms had been redecorated by working groups of patients and nurses, and adorned with educational pictures featuring the adventures of 'Nervy Ned'. Furthermore, a form of what he called group projection methods had been introduced – a species of drama therapy in which patients in each of the eight wards in turn were required to devise and present to the whole unit a play setting out some personal problem, and the audience was asked to consider possible solutions. The nurses, often pressed into service in this activity, also presented their own plays in two series, one demonstrating the family dynamics underlying common neurotic problems and the second a re-enacted psychiatric clinic – again with the expectation of audience response.

By this time, there had also been changes in the social organisation of staff and patients. The nurses were having two 'lectures' each week, one being didactic and the other a general policy meeting – the whole involving what Jones called a 'constant revision and scrutiny of group methods by nurses and doctors.' There was also a one-hour general meeting of the entire ward community. A more detailed account of this regime is available in Murto (1991).

Reflecting in 1983, Jones reported:

As they (the patients) all had the same clinical condition, common sense dictated that we should begin to treat them as a group. So we had daily meetings with 100 men and all staff on duty. . . . It was tremendously exciting as patients and staff were working together in furthering treatment with the patients themselves being a valuable resource for teaching. Moreover it helped to undermine our unpopularity as we were inevitably trying to get them back into army service. So they listened with open ears to their peers. We were there as resource people and didn't say too much because there was always a nucleus of patients who understood their clinical state as they learned what we

had learned about the lack of homeostasis in relation to their exercise physiology. (Barracough, 1984)

It is worth specifying the ways in which this practice has, and – in the light of our understanding 50 years on – has not, the features of a therapeutic community. First, Jones introduced, apparently for the first time in psychiatry, the use of the large group – though the point is inadequately acknowledged in other historical accounts (*cf.* Kreeger, 1975 p.17). There had been earlier examples elsewhere, for instance in the field of progressive education where in certain residential regimes something similar occurred as part of an ideology of self-government (Bridgeland, 1971; Farquharson, 1991; see also Murto (1991) for a comparison of Makarenko and Jones). But there is no evidence that Jones was aware of these in the 1940s or was influenced by them. The large group has subsequently developed in various manifestations. Most prominently, it has persisted in the form of the community meeting as a virtually universal feature of therapeutic community regimes, where it constitutes an essential technique for introducing a social dimension into therapy, and it has been the subject of a good deal of conceptual analysis and some empirical research. Outside the therapeutic community, the large group has a place in training in the fields of psychotherapy and human relations (e.g. in the Tavistock/Leicester Conference, Rice, 1965) and as a free-standing form of therapy (as developed especially by de Maré (1975) and others within the field of group analysis).

Secondly, Jones developed the idea that, within the boundary of the unit, treatment was considered a continuous process operating throughout the waking day and over every aspect of the life of the patient. Although this also was later to become a well recognised principle in therapeutic community practice, it clearly had a relatively restricted meaning in the Effort Syndrome Unit, where much of the emphasis was on the staff-led educational task of getting the patients to understand the mechanisms underlying their psychosomatic complaints. In particular, it was not associated in that setting with a strong emphasis on patients selecting their own activities.

Thirdly, the Unit developed some use of small groups with this same educational end in view. These included informal nurse-patient working groups, but more particularly a variety of socio-drama. It is unclear to what extent the latter were consciously based on the work of J. L. Moreno, which was well-developed by that time in the USA (Davies, 1988). Jones may well have known of it, though he never cited it in the early reports. However, Moreno subsequently visited the Belmont Unit several times (Whiteley, 1980).

Fourthly, Jones recognised that changes in the power structure of the unit were inevitable. More open communication resulted in some flattening of the hierarchical relationship between doctors, nurses and other staff, and the patients. In particular, the therapeutic potential of the relationship between longer-stay patients and newer recruits emerged as crucial. Some emphasis has been placed on these points because of the problem presented to historians of the therapeutic community movement by the relationship between Maxwell Jones' contribution and that derived from work at the Northfield Military Hospital. To that issue we shall return shortly; meantime, this account must be taken one further step.

At the end of the war, the Maudsley was asked to take responsibility for a 300

bed unit at the Southern General Hospital, Dartford, a military establishment designed to assist in the rehabilitation of the most disabled among the large numbers of prisoners of war returning from Europe. Jones was psychiatrist in charge of this unit. Its work combined two features – a replication of the Effort Syndrome Unit inpatient regime and a substantial, and successful attempt to recruit the local community to this task of rehabilitation. As regards the former, the six cottages, each housing 50, men had a daily community meeting; many of the Maudsley/Mill Hill staff had transferred there and were able to sustain ‘a supportive environment where the trust level was high (and) the men discussed their fears about returning to society and to their wives and children born in their absence, their adequacy as husbands, and so on’ (Barraclough, 1984). There was a patients’ committee and staff groups. Travelling around the local area, as he records, on a push-bike, Jones obtained the help of some 70 local employers who supported the men in part-time work. Difficulties and psychological problems at the workplace became also the subject of discussion within the communities. Some 1400 men passed through the Dartford Prisoner of War Unit in the space of 11 months.

Clinical practice at Dartford did not greatly advance the proto-therapeutic community in any technical sense. But it demonstrated the successful application of some of its principles to a somewhat less homogenous group of patients, introduced the emphasis on purposeful work which was to become a significant feature of the Maxwell Jones model of the therapeutic community, emphasised the crucial importance to the life of the institution of the social environment in which it is set and (foreshadowing the later work at Dingleton) raised the possibility of close collaboration with this wider network. It also marked the end of Jones’ specialist career in the psychiatry of psychosomatic disorder.

The work of the two Early Experimental Communities is described in the chapter of that name which opens *Social Psychiatry: A Study of Therapeutic Communities* (1952), Jones’ first book-length account. At discharge, 12% of the first 100 Dartford cases remained clinically unimproved, and only 8% were not placed in employment (though the benefits of a full-employment economy were acknowledged). A follow-up postal survey by the Ministry of Labour, three and a half months later, revealed that 610 of the 687 patients admitted during a six-month period were in work or training. This excellent outcome, together with that found among the much less disturbed population passing through the Army Resettlement Units, persuaded the Ministry of Health to establish the experimental Industrial Neurosis Unit at Belmont. Its purpose was to investigate the rehabilitation of unemployed civilians – casualties of society rather than of war. Jones went there in April 1947. The unit was eventually to become internationally famous and to develop into the Henderson Hospital.

The Northfield Contribution

We come now to an entr’acte in this chronological account. Of major significance in the history of the therapeutic community were events, essentially unrelated to Maxwell Jones, which took place at Northfield Military Hospital (Hollymoor Hospital), Birmingham. These have been widely written up (Main, 1989; Bridger, 1990) – most recently and attractively by Harrison & Clarke

(1992). They are of inescapable significance, however, and must be briefly restated here.

In April 1942, Northfield became a military hospital and rehabilitation unit for soldiers with neurosis, most of whom had been treated earlier in the war in the Emergency Medical Services centres. It came under the command of Army Psychiatric Services which, throughout the war, were heavily and constructively influenced by ideas and personalities associated with the Tavistock Clinic. J. R. Rees, pre-war Director of the Tavistock, had been appointed head of Army Psychiatric Services in 1939 in the rank of Brigadier, and Dicks (1970) has argued that it was the relative independence of the Tavistock tradition – neither in mainstream psychiatry nor narrowly committed to psychoanalysis – which resulted in its selection to respond to what was predicted to be unique scale of psychiatric demands resulting from the war (see Manning, 1989). Among the personalities significantly involved with what later became known as the two Northfield Experiments were the psychoanalysts Wilfred Bion, John Rickman, Harold Bridger and S. H. Foulkes, and the psychiatrist T. F. ('Tom') Main.

The first 'Northfield experiment' occupied about six weeks in 1943, but there had been a precursor in work briefly undertaken by Rickman at Wharnccliffe Emergency Hospital, Sheffield (Bion, 1961). By 1943, Rickman was in charge of a Hospital Wing at Northfield and Bion was posted to command the Rehabilitation Wing, which had developed serious problems of 'slackness, indiscipline and aggressive untidiness' (Bridger, 1990). Bion and Rickman determined to meet these problems by building on their previous experience at Wharnccliffe. The essential step, as Harrison and Clarke make clear, was an organisational diagnosis: 'the difficulties were symptomatic of the neurosis of the whole unit and the organisation of the hospital was a 'retreat' from neurosis'. This military language is reflected in the earliest account of the experiment (Bion & Rickman, 1943) – what was needed was 'the sort of discipline achieved in a theatre of war by an experienced officer in command of a rather scallywag battalion', namely, an accurate identification of the enemy (neurosis) and a determination to attack it together. Harrison & Clarke summarise what occurred:

The soldiers were given opportunities to realise that the solutions were largely in their own hands. (Bion) achieved this by apparently relinquishing his responsibility for solving all the problems presented to him and forcing the group to fall back on their own resources. In practice, he paraded all the men and presented them with five regulations and an announcement that there would be a 30-minute daily parade 'for making announcements and conducting other business'. His covert intention was that the meeting would provide a framework for men to gain insight into their activities and the progress of the unit as a whole: 'the first step towards the elaboration of therapeutic seminars' (Bion & Rickman, 1943).

The next few weeks saw a marked change in the performance of the men and the unit. The Commanding Officer remarked on the improvements in cleanliness. The parades developed into constructive and active meetings.

The five regulations included orders that men were to belong to one or more activity groups and that they could create a new group if nothing suitable already

existed. A range of activities developed, but each involved only a few men. Bion 'reported this back to the daily meeting, suggesting that the whole enterprise was a facade' - like the 'eyewash' (as the men characterised it) of much of what went on elsewhere in the Army. He provided no further elaboration, 'leaving the audience looking as if they felt they were being 'got at' ', and thus encouraging them to reflect on their own behaviour and recognise that many of their perceptions of the Army were actually projections of their own internal conflicts. (Harrison & Clarke, 1992).

Despite this apparent success, the experiment was brought to an abrupt conclusion when Bion and Rickman were posted away from Northfield. Harrison & Clarke briefly review the reasons which have been advanced for this: the intolerance of the military establishment of the disarray surrounding the early weeks of a self-managing unit ('the chaos in the Hospital cinema hall, with newspapers and condom strewn floors, etc.' - de Maré, 1985); the implicit conflict between the military need to prepare men for return to service and the assumption of most of them that health entailed a return to civilian life; Bion's strict handling of a particular incident of financial dishonesty involving officers. But the important lesson, taken over into the second Northfield Experiment, concerned failing to involve the wider environment (in this case, the whole hospital community and its administration), which came to be seen as a necessity if an unconventional therapeutic regime was to become established and survive.

The leading protagonists of the second Northfield experiment were Foulkes, Bridger, and Main. Foulkes, a Frankfurt-trained psychoanalyst, had been at Northfield from 1943 and initially was practising small-group therapy (as he had in private practice from 1940). Bridger, originally a mathematics teacher from Coventry and by then a major in the Royal Artillery, after several years of experience (like Bion and Rickman) in the War Office Selection Boards, was posted to command the Rehabilitation Wing at Northfield in 1944. Main succeeded Emmanuel Miller in command of the Hospital Wing in 1945. The second Northfield experiment occupied about 18 months and its work was described in a single issue of the *Bulletin of the Menninger Clinic* in 1946 (Main, 1946; Bridger, 1946; Foulkes, 1946), where Main first used publicly the term 'therapeutic community':

A Therapeutic Community

The Northfield Experiment is an attempt to use a hospital not as an organisation run by doctors in the interests of their own greater technical efficiency, but as a community with the essential aim of full participation of all its members in its daily life and the central aim of the resocialization of the neurotic individual for a life in organised society.

What were the practical manifestations of this experiment? First, an organisational change brought the hospital and rehabilitation wings into closer relationship. Foulkes was able to extend the use of small group therapy from the former to the latter, and a wide range of educational activities, arts and crafts, recreational activities, but also industrial trades, became available. For his part, Bridger was able to identify himself as 'social therapist' to the hospital as a whole, using the device of a social club in which men were expected to take responsibility for the

organisation of their own activities. Bridger (1990) shows clearly the central place given to stimulating mutual help and responsibility among the patients, and to the wide range of activity groups both within the hospital and in the wider locality - maintenance work in local Child Guidance Clinics, groups in industry, etc. Patients were seen daily by their psychiatrist and there were both weekly ward meetings and a hospital-wide meeting of ward representatives with senior staff. Bridger comments:

Despite a constantly changing patient population, committee meeting minutes make it possible to trace trends of a society developing in almost direct proportion to a growing sense of achievement and responsibility. At the beginning there was a collection of individuals, most of whom were self-appointed ward representatives, airing personal grievances and grumbles. Now the meeting of the ward committees is a constitutional body conscious of its value and responsible to the hospital community as a whole. (pp. 81 - 2)

How, then, are we to understand the interplay between the work at Northfield and that of Maxwell Jones? Manning, who discusses this matter at length, suggests it is an example of the familiar phenomenon of simultaneous scientific discovery. Clearly there are both similarities and contrasts. In both the Effort Syndrome Unit at Mill Hill (but not hospital-wide) and at Northfield, there came about a setting aside of conventional psychiatric approaches involving a power hierarchy (authoritarian doctor/ passively recipient patient) in favour of a more egalitarian, self-directed approach to treatment. In this respect, Northfield was more radical, and the policy perhaps more consciously contrived, than at Mill Hill. Both used a combination of large and small groups, but here Jones seems to have the priority in terms of time. On the other hand, as Manning (who himself later made distinguished contributions as research sociologist at the Henderson Hospital) accurately points out, Jones' work lacked any substantial theoretical basis and was therefore inadequately conceptualised, particularly in terms of social analysis. By contrast, at Northfield there was a clear theoretical background in psychoanalysis, modified by the Tavistock-style appreciation that neurosis is closely linked with poor social relationships which it is the task of the hospital organisation to re-examine and adjust.

There is not much evidence that Jones was aware of the Northfield work as it was going on. But Bridger visited Mill Hill before taking up his appointment at Northfield and later (1990) wrote, concerning 'hospitals . . . which influenced the strategy and practice I eventually formulated':

The first, Mill Hill, a neurosis centre in the EMS seemed to me a large hive housing a conglomerate of every type of treatment - physical, psychotherapeutic and psycho-socio-therapeutic, where the patients seemed incidental. In Maxwell Jones's ward everyone was taking part and shared in the various therapeutic tasks - but it was a relatively closed system and centred on Maxwell Jones himself. I was later to compare his approach to that of Joshua Bierer, who also used a dependency closed-system relationship in his ward at Northfield as the setting for his therapeutic work. After the war, of course, Maxwell Jones had much more scope to develop hospital wide activities of which he has written fully (1968). (pp. 76 - 77)

But Jones seems to have been sensitive to this lack of relevant background. Both in Edinburgh and at the Maudsley, the psychiatric tradition had been generally antipathetic to psychoanalysis; nevertheless, by 1947 he had entered a training analysis with Melanie Klein (pursued for three years and not completed) and had supervision within the Institute of Psychoanalysis with Paula Heimann 'because of the need I felt to improve my skills in group psychotherapy and psychodynamics generally.' Commenting much later, Rapoport (1991) wrote:

At the close of the war the psychoanalysts who were qualified returned to their private practices. Maxwell Jones was protected from this by not having qualified as a psychoanalyst. He was, furthermore, positively orientated to parts of orthodox psychiatry – however critical he was of other parts. (He always referred to Henderson in his work, and he was loyal to his mentor and protector Aubrey Lewis.)

And Hinshelwood (1991), himself a psychoanalyst and now Director of the Cassel Hospital, adds in respect of Jones' ideas of personal learning through a social environment and a social movement:

Psychoanalysis has proved much more stuck in its individualistic orientation, and it would have been more hampering for Maxwell Jones whose horizons were set on major social change. To that extent he was a child of his times, and psychoanalysis was not useful for him'.

Still, psychodynamics, chiefly in the psychoanalytic and group analytic traditions, has continued to make a potent contribution to therapeutic community theory and practice.

The other factors identified in Manning's discussion of the later influence of Mill Hill and Northfield are power and charisma – the former social and the latter personal attributes. Both Jones and Main were senior psychiatrists; Main was five years the younger, but had ended the war with the kudos of military service and in the rank of Lieutenant Colonel (Jones remained a civilian). In peacetime practice, both were powerful enough to dictate in some detail the regime which should operate in units for which they had clinical responsibility, and Bridger attributes Jones' later influence to his medical consultant status. His place in the psychiatric establishment – the Maudsley connection, the World Health Organisation, government committees – was also significant.

Within the therapeutic community movement, Main emerged as by far the most powerful of the Northfield group, becoming Medical Director of the Cassel Hospital in 1946, immediately training as a psychoanalyst, and retaining the Directorship until his retirement 30 years later. At the Cassel, he developed a distinctive version of the therapeutic community which retained within the treatment regime a more prominent place for individual and family psychotherapy or psychoanalysis. He wrote and travelled somewhat less widely than Jones, but there exists a network of organisations in the United States – Chestnut Lodge, the Austen Riggs Centre, the New York Hospital – adopting a very similar philosophy (Hinshelwood, 1991). The influence of Main and the Cassel Hospital has been the subject of a commemorative issue of *Therapeutic Communities* compiled and edited by Denford (1993), which includes a comprehensive bibliography, and Main's Collected Papers have also been published (1989).

We now return to consider the further work of Maxwell Jones and to some discussion of the charisma question .

The 'Therapeutic Community Proper'

Without being inappropriately swayed by notions of a mid-life crisis (Erikson, 1950), it is worth remarking that Jones became Director of the Industrial Neurosis Unit at Belmont in his fortieth year. Renamed successively the Industrial Rehabilitation Unit and the Social Rehabilitation Unit, it became in 1959 the Henderson Hospital. Thus, the sophisticated concepts and practice of the therapeutic community elaborated there were the work of a man in his maturity and at the height of his considerable abilities. His subjective account (1968) of this transition from organic to social psychiatry starts by noting the fragmented and frustrating state of psychiatry in the 1930s:

Anyone with an enquiring mind was driven to seek an orientation which seemed to offer promise for the future and some sort of satisfaction for the patient . . . out of necessity I was driven to explore the biochemical and endocrinological fields in relation to psychiatry . . . and learned enough to realise that, with my limitations and the limitations of the field, I would not find the answer to psychiatric treatment in this direction. . . . The war years were my salvation.

The conviction of the fundamental effectiveness of therapeutic community approaches, and the urge to demonstrate it, remained his guiding principles throughout the Belmont/Henderson years and beyond. Nevertheless, a characteristically astringent comment by Aubrey Lewis (1952) should also be noted:

For the socially directed work which began during that period he was less well prepared. . . . Dr Maxwell Jones has carried over much of his earlier scientific training and experience to the conduct of that experiment . . . and to its use for research. But faith and zeal are effective in carrying through a pioneer social venture when habits of objective verification and severe stage-by-stage appraisal would impose delays or be out of keeping with the aims of the project. Dr Maxwell Jones wanted to take the tide at the flood, in the post-war period. . . . He has demonstrated the effect of such a therapeutic community as he developed at Belmont upon the mental health and occupational fitness of men whose character and medical history argued badly in these regards. What he has not demonstrated so clearly, though it can be inferred from what he has accomplished and is known to those in touch with his work, is the unremitting energy, sustained purpose and enthusiasm which he has put into this difficult enterprise. To these qualities and his judgement and experience it chiefly owes the success'

But of his commitment to this venture there is actually no doubt: it is reported that during this period he rejected invitations to consider both the clinical directorship of the Maudsley (in succession to Eric Guttman) and the Chair of Psychiatry at Birmingham (Merry, 1991).

Julius Merry was recruited by Louis Minski (then Physician Superintendent at Belmont) and assigned to be one of the junior doctors on the Industrial Neurosis

Unit from September 1947; He remained for five years. Merry has provided a portrait (1991) of Jones in middle age:

Thus I met Max, as everyone called him, a well groomed, clean shaven man with a strong chin, and tightly combed scalp hair. His accent was a mixture of Scottish and American, and he often sported a bow tie. He drove a small two-door Ford Popular which I learned he had borrowed and later bought from a girl friend. Max's firm had on it several supernumerary registrars who were doctors who had served in the Army and were going to pursue a career in psychiatry . . . [Merry names Ben Pomryn, Julius Rowley, and Tom Freeman, but there were also others.]

Max had very high clinical standards and he was a hard worker. He was in his office at 8.00 am and had started work while I was contemplating my breakfast. Work for the rest of us commenced at 9.00 am with a meeting of the entire community. But that was not early enough for Max, so he began to have an earlier meeting with a selected group of patients at 8.30 am. Max would work through the day with individual patients and small groups. He was a meticulous note taker. His notes were clearly written and he always took a Maudsley-type history. He was a clear thinker and expressed himself well. It was always a pleasure to listen to his contributions at the weekly case conference held with the entire staff of the main hospital [including another charismatic figure, William Sargent whose unit exploring the use of physical treatments was elsewhere in Belmont]. As a contributor to these case conferences Max was head and shoulders above the rest of the senior medical staff for his analysis of the case and for his reasons for reaching a diagnosis and proposing a plan of management.

[Merry describes Jones travelling each afternoon to St. John's Wood for his analysis with Mrs Klein] . . . He could fall asleep with ease during the train journey or he would engage a fellow traveller, usually female, in conversation. He was a charming man and there were many young women who before they knew what had happened had become volunteer workers at the unit. Max was, through his charm, a great recruiter of women volunteers and permanent staff to work at the unit. . . .

A constant theme of Max was the unnecessary role of the medical doctor as a therapist. He could see the day when the therapeutic community would not need the leadership of a doctor-therapist. Thus from time to time he would argue that for the registrars, including the older supernumerary registrars, it was not necessary for them to spend time studying for the DPM. Of course this was felt as nonsense by registrars who were married and depended on the DPM for promotion. Moreover they were angered by the knowledge that Max had worked hard to get his MD when he was already a consultant and in that sense the MD was just a gong. This anger was also fed by the fact that Max was a bachelor and had no immediate family responsibilities and surely also by jealousy of his intellect, his personality and his achievements. . . . [Jones lived initially in the Belmont doctor's mess, although later in this period he married his first wife, Kerstin.] . . . Thus, although the concept of the therapeutic community was accepted by the four junior doctors on the unit there was a rift between the older married registrars and Max.

(This) . . . continued to the point that Max wondered whether there was any point in sustaining the Unit. A meeting of the Unit medical staff was called at one time to discuss this. The other junior doctors were all for calling it a day and it fell to myself as by far the youngest doctor to rally them to support what I saw as a most important contribution

to psychiatry. The Unit survived. I was young, unmarried and starry eyed about Max but in retrospect I, like Max, had appreciated neither the depth of rivalry nor the day-to-day problems of the older married registrars with children. The medical staff failed to work through this problem.

Apart from the intra-Unit tensions, there was a constant threat to the Unit from the main hospital. The Unit was a wing of the hospital contiguous with the main building. There was always a stream of professional visitors . . . they came from the UK and from abroad from Europe, the Americas and as far afield as Japan. But there were no visits from the Senior Medical Staff of the main hospital. From these Senior Staff there was condescension, scorn, even open hostility until at one point the Management demanded that the Unit be closed. The then Regional Board instigated an enquiry headed by the late Professor Desmond Curran. The enquiry was thorough and lengthy and eventually found no good reason for closing the Unit.

Practice at Belmont has been described several times (Jones, 1952; Whiteley, 1972, 1980; Manning, 1992; Murto, 1991). The Unit initially accommodated 100 patients in four wards, although the occupancy had dropped to about 40 in the 1970s, thus freeing space for a wide range of activities. Later, following a fire, it was re-housed from the original Victorian work-house building into what had previously been the nurses' home. Manning's account emphasises the development of the unit from being experimental to achieving a place within psychiatry as an established, specialised facility. Research was always an important feature at Belmont: the early years were reported in a number of publications including Jones (1952), and the next phase in a stream of studies collected in Rapoport's *Community as Doctor* (1960). After Jones departed, this tradition continued in the work of Whiteley (1980), Manning and others.

Initially, the unit catered for persons identified by Disablement Resettlement Officers of the Ministry of Labour, or by psychiatrists (or both), all over the country as the 'hard core' of the chronically unemployed. Psychiatrically, they had for the most part chronic neurosis or character disorder, but they were also described as including 'some of the most anti-social elements in society - people who have served prison sentences, drug addicts, prostitutes and so on.', who 'frequently exert a strong negative influence on the environment from which they come', and who were 'much more ill' than the patients at Dartford (Jones, 1952). Over later years, the clientele gradually became more identified as psychopathic personalities (hampering, indeed, the therapeutic community movement through the spread among some psychiatrists of the opinion that if this approach was 'good for psychopaths', it could not be good for any other type of patient).

By the time of his 1952 account, most of the characteristic elements of the Maxwell Jones type of therapeutic community were in place. From 8.00 am to 9.00 daily, patients undertook work activities to keep the ward environment tidy; on weekdays, there was some form of community meeting from 9.00 to 10.00 for all patients and all staff free to attend; there were patients' work groups from 10.00 to 12.00 (and staff meetings) and from 2.00 pm to 4.00, with a wide range of activities; free time from 4.00 to 7.00 during which some patients on pass could leave the hospital; and from 7.00 to 9.00 an organised social programme, prepared by a patients committee and 'readily censured at

the group discussion should it fail to cater for all needs' In addition, there was a full range of hospital-wide social activities. In the early Belmont years, the full range of physical therapies and individual psychotherapy were also used, although reliance progressively became placed on the effectiveness of the social processes and group psychotherapy to achieve the desired outcomes. An example of these processes (dealing over about ten days with the occurrence a number of thefts in the community) may be found in Jones (1952, pp. 165 – 187).

Behind this time-table lies the theory that in such a rich social environment every patient would find opportunities to replicate the problems they had experienced in the outside world, the whole being open to scrutiny, analysis, challenge, and reparation within the community interaction. It was in this sense that Jones claimed (as well as the principles that 'everything is treatment' and 'all treatment is rehabilitation') that 'all patients (once admitted) should get the same treatment.'

The staffing of the unit has been analysed by Rapoport *et al* (1960) in terms of 'core staff' – the most highly trained (doctors, the charge nurse, the psychiatric social worker, and the psychologist), 'adjunctive permanent staff' (staff nurses who, initially, were medically but not psychiatrically qualified, workshop instructors, and disablement resettlement officers) and the 'transient staff'. The latter comprised social therapists, of whom Rapoport wrote:

(They) are untrained in any of the core or adjunctive professional skills, but are employed in the position of assistant nurse. (They are) brought in for six months to a year to implement the Unit's particular approach to treatment rehabilitation. In many cases they have had some university education, usually in social work, but they seldom have any nursing training. They do not, however, form part of any definite career line, and go into various occupations after their experience in the unit.

Briggs (1986), reported in Murto (1991), adds from a recorded conversation with Jones:

We soon found it almost impossible to find young people in Britain who wanted to work in this setting, for low pay and with no opportunities for advancement – it was a dead end job. . . . About this time, we had a social work tutor from Norway come to visit the unit . . . she was impressed and asked if she could send some of her students to get experience.

Murto explains that the practice of recruiting social therapists from Scandinavia started in this way, and adds that the advantages were their democratic character, that patients could in turn teach them something of the language and culture, and that they improved the morale of patients and staff 'for they were full of life and ideas'.

The work at Belmont attracted a large number of visitors – psychiatrists, social scientists, criminologists, etc. – both academics and practitioners from Britain and overseas, so much so that special 'visiting day' arrangements had to be set up. In many countries, the processes of liberalising the old mental hospitals were then getting under way, and ideas emanating from Belmont were highly influential – though not, of course, to be exactly imitated. Thus, Clark (1965)

later defined a helpful distinction between the 'therapeutic community proper' (Belmont in pure culture) and the 'therapeutic community approach' (a partial application of these ideas in the wider mental health field). Jones personally became an increasing force, not only in Britain in connection with such bodies as the Ministry of Labour's National Advisory Council on the Employment of the Disabled (for which he received the CBE in 1954), the board of the Tavistock Institute of Human Relations, and in his representations to the Royal Commission on Mental Illness and Mental Deficiency (where the provisions for psychopathic disorder in the Mental Health Act, 1959 owe much to this input), but also internationally. He travelled world-wide, partly as consultant on Rehabilitation to the World Health Organisation (Jones & Stoller 1952) and increasingly as a lecturer and consultant.

Uncertainties about what was going on nevertheless remained. The question: How much is the man and how much the method? arose in various quarters (e.g. World Health Organisation, 1953). Accordingly, Jones set about establishing a programme of proper sociological research. On one of his visits to the USA, he recruited an anthropologist, Robert Rapoport to come to Belmont – initially (in 1954) to study the phenomena of psychopathy and its treatment. Subsequently, the focus shifted somewhat towards a precise characterisation of the Unit's regime. In 1955, generous funding by the Nuffield Foundation enabled a large research team to be appointed. The subsequent studies of Rapoport and his co-workers described in much more detail and with less bias than Jones' own publications, and with a sound basis in theory, exactly how Belmont operated. *Community as Doctor* (Rapoport, 1960) described the regime, which did not differ from that set out above (except that the community meeting was occurring earlier, so that 'the 8.30' entered therapeutic community mythology as something of a technical term) and proceeded to evaluate it – clarifying, for example, the place of social control in the scheme of things. This study also defined the four cultural principles – democratisation, permissiveness, communalism, and reality confrontation – which although by no means uncontroversial, have broadly guided therapeutic community theorists ever since.

Jones himself, having set the Rapoport investigations in motion, evidently became uncomfortable with them – early on, there was one co-authored paper (Jones & Rapoport, 1956), but none later – and he effectively distanced himself from them. He left Belmont at about the same time as it became an independent hospital, then renamed the Henderson, and within a few months of the publication of *Community as Doctor*. Jones was disappointed in the book, partly because it disconfirmed his belief that the therapeutic community regime was applicable to every type of patient – Rapoport demonstrated that less robust personalities might do badly in a confrontative regime – and it was not well received by the Belmont staff generally. Nevertheless, he later acknowledged it as 'a rewarding, but painful, learning situation for us all' (Jones, 1968).

Manning later collaborated with Rapoport in reviewing the impact of this study (Manning & Rapoport, 1976), and replicated some of the initial work. His more general account of both the significance and the limitations of *Community as Doctor* should be consulted (Manning, 1989 p.103 ff.). The importance of that book resides in having firmly established the features of the Maxwell Jones model of the therapeutic community, and for its prominence within a research tradition

which Jones brought to Belmont from his Maudsley background and which has persisted in the therapeutic community movement.

The Therapeutic Community Movement

A second brief entr'acte here will suffice to note the further evolution of the therapeutic community in Britain after Jones' departure from the Henderson. So far as the Henderson Hospital itself is concerned, the story up to 1980 has been well recorded by Whiteley (1980) and later developments by others (e.g. Norton, 1990). Whiteley reviewed the continuing stream of research studies which emerged during the 1960s and '70s (and which has continued), the major contributions to professional training (especially, perhaps, of social workers and probation officers), the contributions to policy development in the fields of criminology and the management of psychopaths, and the ambivalence of conventional psychiatry which, on the one hand, has regarded it as a valued specialist resource in the treatment of patients with severe personality disorder and, on the other, has launched repeated attacks designed to get the hospital closed.

In Britain, parallel to Jones' work at Belmont, the liberalising of the mental hospitals was proceeding fast. Examples include the work of David Clark at Fulborn from 1953, later described in *Administrative Therapy* (Clark 1964) and in several papers, and that of Dennis Martin, appointed consultant at Claybury in 1955 and who contributed *Adventure in Psychiatry* (Martin, 1962). Corresponding developments in the United States produced such work as *The Mental Hospital* (Stanton & Schwartz, 1954), *Human Problems in a State Mental Hospital* (Belknap, 1956), *Asylums* (Goffman, 1961), and *Ego & Milieu* (Cumming & Cumming, 1962). This forms part of the rich transatlantic influence noted earlier.

Developments in the therapeutic community movement in Britain from the 1960s have been analysed by Manning (1992). His account defines two further stages. During the 1960s, enthusiasm for the therapeutic community began to wane partly because, within the life of the hospitals, it was not found to offer the comprehensive revolution in the social organisation of custodial institutions which many idealists sought, and also because hospital-based care was being circumvented by moves towards care in the extra-mural community. Although therapeutic community concepts began to be applied in community care settings, the movement as a whole entered a phase of what Manning calls 'legitimacy deficit'. In medicine generally, a new idea may make some initial headway on the basis of the enthusiasm of its advocates, but it will not ultimately survive unless it satisfies the criteria of scientific research. Psychiatry was not at that stage convinced by the protagonists of the therapeutic community. Nevertheless, the therapeutic community movement did not die out, either in Britain or elsewhere. Somewhat to the surprise of its critics, it persisted as a form of practice during the 1970s and 80s and developed a growing literature of sound, if unexciting, research. This process was aided by the formation in 1972 of the Association of Therapeutic Communities and by the establishment in 1980 of its Journal and of a number of training activities. Kennard (1986) described this as the shift from a 'movement' (of social reform) to a 'method' (of therapy).

Greater clarity has been achieved about the several models of the therapeutic community, and the several historical pathways through which they have developed – progressive education and the Planned Environment Therapy Trust (Farquharson, 1991), the Northfield experiments and the work associated with the Cassel Hospital (Barnes, 1968; Main, 1989), residential treatments for alcohol and drug abusers including large elements of self-help (the Concept House model, De Leon & Zeigenfuss, 1986), and others. But the version associated with Maxwell Jones, sometimes referred to as the ‘democratic’ model, has had the widest influence and is perhaps that towards which all have tended to converge. While individual therapeutic communities tend to develop and decline according to changing local circumstances, the movement remains firmly rooted in Britain and North America, in some European countries, notably Holland and Italy, in Scandinavia, Israel, and Australia.

Wider perspectives

To rejoin the chronological narrative: by 1959, the essential features of Maxwell Jones’ model of the therapeutic community were firmly in place. The last 30 years of his life were characterised by two themes: experiments in the application of these principles in a wide variety of institutions, mainly in North America but also at Dingleton (‘clinically the most creative period of my life’, Barraclough, 1984), and the extension of those ideas, which he increasingly referred to as ‘social learning’, to the wider social and political scene. The latter was evidently accompanied in his later years by an internal, spiritual exploration.

Among the many visitors during the early years at Belmont was an American psychoanalyst, Harry Willmer; he also visited Main at the Cassel and T.P. Rees at Warlingham Park and, as he later remarked, ‘saw what I believed was the future hope of psychiatric hospitals’ (Willmer, 1991). Later, when teaching at Stanford University, California he was instrumental in Jones obtaining a one-year post as Visiting Professor. During this period, the lectures were written (though actually delivered in Washington, DC) which later became *Social Psychiatry in Practice; The Idea of a Therapeutic Community* (1962) – arguably the single most influential book in promoting the therapeutic community world-wide. Willmer is himself an exemplar of the proliferation of such units, being personally responsible over the years for a 38-bed ward at the US Navy Hospital, Oakland (where he acknowledges a debt to both Jones and Main), a VA Hospital ward for schizophrenic veterans, a unit for Vietnam combat veterans, a therapeutic community at San Quentin prison, and a unit at the Langley Porter Institute for casualties of the Haight/Ashbury drug culture. Jones visited and consulted at each of these units in turn (Willmer, 1991).

His next three years were spent as Director of Education and Research at Oregon State Hospital, Salem and Clinical Professor at the University of Oregon Medical School. With the assistance of an enlightened Medical Director, Dr Dennis Brooks, Jones was here to have his first personal experience of moving a large, traditional mental hospital (where *One Flew Over a Cuckoo’s Nest* was later filmed) to one showing most of the characteristics of a democratic system. He also continued to lecture all over the United States and to write.

He was ultimately dismissed from this post. According to Jones:

What happened has become all too familiar to me or anyone else attempting to be a change agent. Although the democratic system we were developing helped staff and patient morale as well as treatment results, the new freedoms signalled dangerous signs of change to conservative, hierarchical forces in psychiatry in politics, public opinion, big business and bureaucracy generally. Disapproval emanated from the Governor's office, which unfortunately was situated near the hospital. Rumour, misinformation and prejudice followed. I was made to feel I was no longer welcome and it was hinted that I was a Communist! (Barraclough, 1984)

However, Clark (1991), in the context of discussing the abrasive and destructive side of Jones' charismatic personality, adds: 'his constant baiting of the all-powerful Governor's wife was said to be the main reason for his dismissal.'

Thus, on the instigation of Professor G. M. Carstairs, Jones became in December 1962 Physician Superintendent of Dingleton Hospital, Melrose. Dingleton, a 400-bed hospital, was already widely respected for having become under the leadership of George Bell one of the first – perhaps *the* first – British mental hospital to have a comprehensive open-door policy, although in other respects it continued to run in the traditional autocratic way. A long-serving member of the nursing staff recalls that the Physician Superintendent was:

a nice man but really isolated from the staff and patients and he treated the hospital as a one-man show. The Matron was very authoritarian and autocratic and quite fixed in her ideas of what was right and what was wrong. People were promoted not so much on the basis of merit but on retirement dates and death vacancies through seniority. (Elliott, 1991)

Jones made a quick start. Within two days, a twice-weekly Senior Staff meeting had been established and within four weeks a Work Therapy Committee. The Hospital Administrator described the effects:

The words therapeutic community meant little. Why the emphasis on egalitarianism? Staff eating with Patients! No more hierarchy, off with uniforms and call me Max! By the end of January 1963 the honeymoon was over and new structures throughout the hospital were the order of the day. Quite a few staff felt their jobs were threatened. All the daily scrutiny was becoming a little tiresome. The number of visitors even became overwhelming. There was a flattening of the hierarchical pyramid but although it meant sharing decisions and authority with junior colleagues and patients it did not absolve those officers from their responsibility. Gradually at first, but eventually most people came to accept the principle of the therapeutic community which attempts to make the greatest use of each person's potential and encourage everyone to play a more adult role in their own treatment or training. By the end of 1963 we had arrived at a position whereby the hierarchy had been truly flattened to make a democratic organisation which provided open communications to all levels and one in which authority could be openly questioned in a constructive way by everyone in the community. (Millar, 1991)

Jones kept a diary throughout the period and described these events in *The*

Process of Change (1982). His own later summary – that he was ‘able to satisfy himself that a traditional mental hospital could become an open system given time and sanction from above’ (Barraclough, 1984) – scarcely conveys the trauma and anxiety, but also the excitement, created by such institutional change. Similar reforms were of course taking place simultaneously in many British mental hospitals (there was talk of the ‘New Moral Treatment’ of the insane) and in some they were explicitly associated with therapeutic community practices. Dingleton represents Maxwell Jones’ personal participation in this wider movement. His own clinical work was mainly with long-stay patients, leaving the admissions wards to his two consultant colleagues, although he held himself available to help any staff or patient in an emergency – providing they first defined it as an emergency. A record of one such incident has been preserved (Briggs, 1991). Murto (1991) gives a more extended account of the Dingleton period.

But the other important aspect of Jones’ work at Dingleton was outreach into the wider community. This was partly to do with ‘community mental health’ (narrowly defined), and partly with the extension of his concepts of social learning into other contexts. A consultation system involving the 60 or so general practitioners in the Borders, local clinics, a crisis intervention service, community nursing, day centres, and group homes were all established. Beyond this was a wide-ranging educational programme involving Womens’ Rural Institutes, church groups, Toch H, and indeed any organisation interested in listening to a small team presenting the work of Dingleton. And beyond this again, Jones with others including personalities such as Sir David Steele and the local nobility established the Border Forum which for a time held discussions – a kind of public community meeting – of such issues as the closure of railways, education policy, or the rural way of life.

Jones took early retirement from the National Health Service in 1969 and, although remaining an inveterate traveller, thereafter made his home in North America. He went first to a Professorship at the University of Colorado and an association with Fort Logan Medical Centre, but he and his third wife, Chris, settled in Phoenix, Arizona. His final continuous contact with a therapeutic community occurred here in collaboration with Dr Leonardo Garcia-Bunuel at the psychiatric unit of Durango Detention Centre, a minimum-security jail in Manicopa County. (Jails in the US penal system are remand facilities; convicted prisoners serve their sentences in penitentiaries). Jones worked part-time at this unit until he moved to his retirement home in Woolfville, Nova Scotia in 1982. Garcia-Bunuel (1991) describes the now familiar process of introducing a daily community meeting, a staff after-group, a patients’ committee, etc., among a population which was at first substantially of personality disordered patients, but increasingly came to include detainees suffering major psychosis.

Alongside a continuing involvement in the clinical practice of therapeutic communities, the final years of Jones’ life were marked by an increasing interest in spirituality. His contacts with Heronbrook House, a Roman Catholic therapeutic community for clergy and members of religious orders, at Knowle, West Midlands brought these strands together. Here, he was staff consultant, member of the Board of Governors, and facilitator of staff and residents’ discussions; he continued to visit periodically as long as he was physically able to travel and sustained a vigorous correspondence with the Director until a few

months before his death (O'Sullivan, 1991). He used the word 'psycho-spiritual' in connection with this community.

On the wider front, he undertook a consultant role to certain teaching activities of the Department of Educational Psychology at a local institution – Arcadia University, Woolfville, Nova Scotia (Little, 1991). Personally, he was concerned to explore as fully as possible the experiences of ageing, bodily frailty (he had a coronary artery by-pass in 1984), and approaching death. His final book, *Growing Old: the Ultimate Freedom* (1988) deals briefly with these matters and describes a discussion group on this theme he conducted at Woolfville University. His religious views tended towards the holism characteristic of the New Age movement (he had referred approvingly to Ferguson's *The Aquarian Conspiracy*, 1981) and he described a number of personal experiences of a mystical nature during the final years (Garcia-Bunuel, 1991).

The Man and the Icon

'The name of Maxwell Jones is probably better known throughout the world than that of any other British psychiatrist': thus Professor G. M. Carstairs in 1968. The basis of that claim (surprising to us in the present day) was, of course, precisely Jones' identification with the concept of the therapeutic community: 'one of the most valuable contributions of social psychiatry' (Carstairs, 1968). By the examples of his work at Belmont and Dingleton as well as in North America, by his 'eloquent expositions' both in individual interaction and in formal lecturing all over the world and in encouraging emulators, by sustaining an extensive international correspondence, but especially (and most favoured by Jones himself) by practical demonstration wherever he found himself in a group setting, he promoted his philosophy of social learning. There are several recorded examples (e.g. Toch, 1991) of his ability to turn an academic lecture into an exciting, instructive, and enraging occasion of mutual learning for sponsors and audience alike.

Such a degree of influence generally derives from rather unusual personal characteristics. The question of charisma in relation to Maxwell Jones has been discussed by Manning (1989) and Rapoport (1991), and also by his friend and near-contemporary David Clark (1991) who comments:

Meeting Max was always an exciting and stimulating experience. He bubbled with enthusiasm, even in his eighties. He was always excited about some new discovery or person or book. He welcomed visitors and new causes with delight, convinced they would have much to offer. . . . Of course there was the other side. He would rage against those who did not see his version of the truth. His joy in elevating the humble was matched by a savage delight in humiliating the pompous, the rigid, the traditional. Sometimes he harried senior office holders, especially older women, quite mercilessly. Often one left his unit infuriated as well as challenged, – but always stimulated.

In talking of his impact on British psychiatry it is important to mention the effect that his puckish charm had on powerful men, especially those senior to him. . . . Certainly attempts to destroy his work were thwarted time and again by powerful protectors who would intervene, even if apologetically, to protect Max and his work – Professor Sir David

Henderson at Edinburgh, the Hon Dr Walter Maclay at the Board of Control, Professor Sir Aubrey Lewis at the Maudsley and Professor Morris Carstairs in Scotland. Max's puckish charm was often deployed with immense effect on the Great and the Good . . .

Max used to speak of himself as a 'change agent'; that he certainly was. He deployed charm, intelligence and erudition in every situation, challenging, questioning, teasing those he met. He changed the lives of many colleagues and patients, he changed several institutions permanently, he made a major contribution to the permanent change in British mental hospitals.

That Jones was not unaware of these matters is evident from the self-critical references which occur repeatedly in his writing. They raise, of course, the issues of leadership and of Jones' concept of an 'open system'. It becomes very clear in, for example, *The Process of Change*, that Jones never thought of psychiatric institutions as being leaderless. Rather, he always argued for notions of multiple leadership, where this function flows around a number of people over time and independently of their ascribed roles or status within the organisation, for the degree of openness and regularity of communication which makes such an arrangement feasible, and for the continuing possibility of democratic challenge to such leadership by any member of the community willing to mount it responsibly (*per contra*, in a closed system, leadership is autocratic, and communication uni-directional and not open to challenge). It is a powerful model.

From a psychodynamic perspective, Jones was himself always reticent in what he wrote. One brief attempt to relate what is known of his family background to certain aspects of the therapeutic community may be quoted:

What is immediately apparent is the early loss of the father, the presence of the strong but perhaps emotionally inaccessible mother who coped resourcefully with a family emergency and the emergence of a rather cosmopolitan cast of characters and environments.

With the therapeutic community concept emerging in wartime practice, Max found a string of opportunities to which he resonated. The archaic father was banished in favour of the peer group; the mother figure was split into a bad external one (Matron) and a good internal one (Sister) assisted by a corps of attractive but untrained youthful nymphets; a total world was created within the manageable hospital premises in which everyone bent their efforts together to understand all that was going on. The giving of affection was part of the sought ethos, and the sharing of decisions served to diffuse responsibility and therefore guilt. When disorganisation mounted and destructive tendencies threatened to gain ascendancy in the community, heroic measures could be taken by the leader to re-create the idealised group - a process which was subsequently identified as sociotherapeutic in that insights were gained by all through participation in the 'oscillations'.

From the point of view of followers - both patients and staff - charismatic qualities were called for by the social temper of the times. (Rapoport, 1991)

Concluding his sociological review of the recovery of the therapeutic community movement from its state of legitimacy deficit - indeed its evolution from charisma to routinisation - Manning wrote:

The therapeutic community is both a scientific innovation in psychiatric medicine and a social movement to change residential psychiatric practice, therapeutic education and the treatment of addictions. In both of these aspects it has worked with some, but not complete, success.

I concur as a clinician in viewing the therapeutic community as a technique – similar in status to, perhaps, a new family of surgical interventions, or a new class of psychotropic drugs – which enables the social dimension to be brought seriously into therapy. Many (perhaps most) psychiatrists are in practice pluralists, accepting something akin to Popper's Three-World model: the world of physical events (in this case, chiefly biological), the world of mental events, and the world of social events (Popper & Eccles, 1977). However, we are generally poor at understanding and mobilising the world of social events and too often, as the psychiatric literature repeatedly attests, take refuge in the unsatisfactory concept of the 'psychosocial' – by which is presumably meant something like an internalisation of the social world. But therapeutic community techniques provide precisely that events in the social world (World 3) may, along with the psychological (World 2) and the biological (World 1), be addressed separately and in their own right.

Moreover, the question 'how much is the man and how much the method?' has an unfortunate overtone. Certainly, Maxwell Jones was a charismatic figure, in some respects much larger than life. But psychiatry is very accustomed to the idea that many techniques, whether psychoanalysis, cognitive therapy, or even the familiar processes of the psychiatric history and the clinical interview, are better applied by some practitioners than others. Any implication, therefore, that the personal skill with which a technique is applied is in some way irrelevant to the outcome is fallacious. Jones was a figure larger than many, but a succession of others have found that they also have sufficient gifts to employ this technical apparatus effectively and to the great benefit of their patients. It is for delivering that technology into the hands of psychiatry and its sister disciplines that the life of Maxwell Jones deserves to be honoured and recorded.

Acknowledgements

This account draws heavily upon a generally laudatory but not wholly uncritical commemorative issue of the *International Journal of Therapeutic Communities* compiled and edited by Stuart Whiteley (1991), which includes *inter alia* a complete bibliography of Jones' publications. Also indispensable is N. P. Manning's *The Therapeutic Community Movement: Charisma and Routinization* (1989). Especially for the earlier years, I have used Jones' largely autobiographical introduction to his *Social Psychiatry in Practice: The Idea of a Therapeutic Community* (1968) and a recorded *Conversation* with Dr Brian Barraclough conducted for publication in the *Bulletin of the Royal College of Psychiatrists* (1984). An important and more recent resource is Kari Murto's *Towards the Well-functioning Community: The development of Anton Makarenko and Maxwell Jones' Communities* (1991), which includes material from interviews with Jones as late as 1988.

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